U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

POLICY INFORMATION NOTICE

DOCUMENT NUMBER: 2009-06

DATE: September 22, 2009

DOCUMENT TITLE: Federally Qualified Health Center Look-Alike Guidelines and Application

TO: Federally Qualified Health Center Look-Alikes
Health Center Program Grantees
Primary Care Associations
Primary Care Organizations
National Cooperative Agreements

Attached are the revised guidelines and application package for the Federally Qualified Health Center (FQHC) Look-Alike Program. This document supersedes Policy Information Notice (PIN) 2003-21, "Federally Qualified Health Center Look-Alike Guidelines and Application," dated August 26, 2003 and all corresponding amendments to PIN 2003-21, including PINs 2006-06, 2005-17, and 2009-04, "Revisions to PIN 2003-21, FQHC Look-Alike Guidelines and Application."

The Health Resources and Services Administration (HRSA) is committed to improving the health of underserved communities and vulnerable populations. The FQHC Look-Alike Program supports the delivery of comprehensive, culturally competent, quality primary health care services to low-income, underserved, and special populations. In an effort to strengthen the FQHC Look-Alike Program and align it with the Health Center Program (authorized under section 330 of the Public Health Service (PHS) Act), HRSA has made extensive changes to the requirements for securing and maintaining FQHC Look-Alike designation. A summary of the changes is provided below.

- **Requirements to Maintain FQHC Look-Alike Designation:** Following initial designation, FQHC Look-Alikes must now submit a renewal of designation application every five years (or as determined by HRSA) to maintain the FQHC Look-Alike designation in addition to the established annual recertification application. The purpose of the renewal of designation application is for HRSA to periodically obtain complete and comprehensive information about the FQHC Look-Alike to ensure that the organization continues to maintain compliance with all program requirements. The renewal of designation application is similar to the initial designation application. Refer to Section III.1., Application Submission Requirements, for additional information on the types of applications.

- **New Application Forms and Tables:** The FQHC Look-Alike application now includes all Forms and Tables that are used for grants under the Health Center Program. The Forms previously used in PIN 2003-21 are no longer a part of the application requirements. In addition, FQHC Look-Alikes must report patient data based on the calendar year (i.e., January 1 – December 31). Refer to Appendix I, Form and Table Instructions, for a listing of all the new Forms and Tables.

- **Organizations Serving Special Populations:** Organizations that are requesting designation to serve a special population authorized under section 330 of the PHS Act (i.e., migratory and seasonal agricultural workers, homeless populations, and residents of public housing) are now eligible to apply for FQHC Look-Alike designation. Upon showing good cause, the following types of organizations are eligible to request a waiver of the 51 percent consumer/patient majority and monthly meeting governance requirements in accordance with section 330(k)(3)(H)(iii) of the PHS Act: (1) any organization serving a sparsely populated rural area (section 330(p) of the PHS Act); and (2) organizations that receive FQHC Look-Alike designation to serve section 330(g), Migratory and Seasonal Agricultural Workers, section 330(h), Homeless Populations, or section 330(i), Residents of Public Housing, only but do not serve the general community (section 330(e)). Refer to Section II.2.B., Program Requirements for Special Populations, for additional information regarding organizations that serve special populations authorized under section 330 of the PHS Act.

- **Health Care Plan and Business Plan:** Organizations are now required to prepare and submit a Health Care Plan and Business Plan that outlines time-framed and realistic goals with baselines that are responsive to the health care needs of the community served and the strategic needs of the organization. The Plans will be used as an ongoing monitoring tool by HRSA and organizations to measure progress in meeting clinical and financial goals. Organizations are expected to adopt the clinical and financial performance measures as identified in Appendix E when preparing the Plans.

- **Letter of Interest (LOI):** HRSA has eliminated the LOI process for the FQHC Look-Alike Program. In lieu of submitting an LOI, organizations that seek technical assistance in preparing an application for initial FQHC Look-Alike designation may submit questions in writing to HRSA's Bureau of Primary Health Care, Office of Policy and Program Development (OPPD) at OPPDGeneral@hrsa.gov. Please indicate "FQHC Look-Alike Program" in the subject line of the email. Organizations may also contact OPPD at 301-594-4300 and their State Primary Care Association (PCA) and/or Primary Care Office (PCO) for assistance in developing an application. Contact information for the State PCAs and PCOs are available on HRSA's web site at http://bphc.hrsa.gov/technicalassistance/.

- **Effective Date of an Approved Change in Scope:** The effective date of an approved change in scope will be no earlier than the date of receipt of a complete request for prior approval, and will extend to the end of the FQHC Look-Alike's current designation

period. The approved site/service should be included the FQHC Look-Alike's subsequent annual recertification or renewal of designation application.

The effective date for this PIN will be six months beyond the issuance date. All organizations, potential and existing FQHC Look-Alikes, are strongly encouraged to use this application guidance upon the effective date. Organizations will be required to meet the new FQHC Look-Alike application guidance requirements twelve months beyond the issuance date. Organizations that are newly designated after issuance of this application guidance will be expected to submit a renewal of designation application five years from the designation date. Existing FQHC Look-Alikes are required to submit a renewal of designation application based on the following designation year:

Year of Initial Designation	Submit a Renewal of Designation Application in this Year
1991 – 1996	2010
1997 – 2005	2011
2006 – 2009	2012

Questions regarding the FQHC Look-Alike Program should be directed to OPPD at 301-594-4300 or OPPDGeneral@hrsa.gov.

James Macrae
Associate Administrator

Attachments

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I. PROGRAM DESCRIPTION AND GENERAL INFORMATION

This Policy Information Notice (PIN) provides information about the Federally Qualified Health Center (FQHC) Look-Alike Program, including an overview of program requirements and instructions for submitting applications for FQHC Look-Alike designation, renewal of designation, annual recertification, and change in scope of project.[1]

1. Legislative Authority

The Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993 amended section 1905 of the Social Security Act (SSA) to create and define a category of facilities under Medicare and Medicaid known as FQHCs. One of the definitions of an FQHC as set forth in section 1861(aa)(4) and section 1905(l)(2)(B) of the SSA is an entity, which based on the recommendation of the Health Resources and Services Administration (HRSA), is determined to meet the requirements of the grant program authorized by section 330 of the Public Health Service (PHS) Act (the Health Center Program), but does not receive a grant under section 330 of the PHS Act. This category of health centers has been labeled, "FQHC Look-Alikes." FQHC Look-Alikes do not receive section 330 grant funding; however, the FQHC designation authorizes eligibility for: (1) Medicaid and Medicare FQHC reimbursement; (2) participation in the 340B Federal Drug Pricing Program; and (3) automatic Health Professional Shortage Area (HPSA) designation. FQHC Look-Alikes are not eligible for Federal Tort Claims Act coverage.

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) modified the definition under section 1905 of the SSA for an FQHC Look-Alike by adding the requirement that the "entity may not be owned, controlled or operated by another entity." HRSA, in collaboration with the Centers for Medicare and Medicaid Services (CMS), issued PIN 1999-09, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities,"[2] issued April 20, 1999, and PIN 1999-10, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities," issued April 20, 1999, to implement the BBA requirements for public and private nonprofit organizations. These documents describe the statutory limits on the involvement of "another entity" in the ownership, control and/or operation of a public or private nonprofit FQHC Look-Alike. Organizations are encouraged to work closely with HRSA if there are questions about the application of these policies.

2. Program Background

The goal of the FQHC Look-Alike Program is to improve the health of underserved communities and vulnerable populations by maintaining, expanding, and improving the availability and accessibility of essential high quality primary and preventive health care services, including oral health, mental health and substance abuse services. These services are provided to low income, medically underserved and vulnerable populations that have limited access to affordable services and face the greatest barriers to care. FQHC Look-Alikes provide a comprehensive system of care that is responsive to the community's identified health care needs and provide services to all persons residing in the health center's service area regardless of ability to pay.

[1] For all terms encompassed in this PIN, please click on the highlighted term for the definition of it and/or refer to the glossary terms found in Appendix B: Glossary.
[2] Web links to these and other policy guidelines identified in this PIN are located in Appendix C, Resources.

In order to maximize access to care for the underserved populations and communities, the FQHC Look-Alike Program was established for entities that do not receive funding under section 330, but operate and provide services consistent with grant-funded programs. As such, FQHC Look-Alikes are expected to demonstrate a commitment to provide access to services for all populations residing in their respective medically underserved communities regardless of their ability to pay and meet all statutory, regulatory, and policy requirements that apply to section 330-funded health centers.

3. Benefits of FQHC Look-Alike Designation

FQHC Look-Alikes are eligible to receive a number of benefits to support activities included in the approved scope of project, which defines five core elements of the FQHC Look-Alike including sites, services, providers, service area(s), and target population. FQHC Look-Alikes are eligible to take advantage of the following benefits:

(a) Purchase discounted drugs under the section 340B Drug Pricing Program.
(b) An FQHC Medicare all-inclusive reimbursement rate.
(c) State Medicaid Agency payment rates under the Prospective Payment System (PPS) or other State-approved alternative payment methodology (see Program Assistance Letter 2001-09 and section 1902(bb) of the SSA).
(d) Automatic HPSA Designation and access to National Health Service Corps providers.

It is important to note that the benefits of FQHC Look-Alike designation apply only to activities that are included in the approved scope of project. An FQHC Look-Alike's approved scope of project may be part of a larger heath care delivery system with other lines of business (e.g., day care center) that are not subject to section 330 requirements and, therefore, are not eligible for any FQHC Look-Alike benefits. Services that are within the approved scope of project but are not covered as an FQHC service by Medicaid or Medicare are not eligible for PPS or cost-based reimbursement.

Refer to Appendix D, Benefits of FQHC Look-Alike Designation, for additional information regarding the benefits identified above. Also refer to PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes," for additional information regarding scope of project.

II. ELIGIBILITY AND PROGRAM REQUIREMENTS

1. Eligibility Requirements

Organizations must meet the following eligibility requirements at the time the application is submitted for FQHC Look-Alike designation. Organizations that do not meet these requirements will be notified that the application is ineligible and offered the opportunity to submit a new application when the requirements are met. In order to be eligible to receive FQHC Look-Alike designation, the organization must:

- Be a public or a private nonprofit entity;
- Serve, in whole or in part, a federally-designated Medically Underserved Area (MUA) or

Medically Underserved Population (MUP)[3, 4] (The list of MUAs and MUPs is available on the HRSA web site at http://bhpr.hrsa.gov/shortage/); and

- Comply with section 1905(l)(2)(B) of the SSA, which requires that an FQHC Look-Alike entity may not be owned, controlled, or operated by another entity.

2. Summary of Program Requirements

FQHC Look-Alikes are expected to demonstrate compliance with the applicable requirements of section 330 of the PHS Act, 42 Code of Federal Regulations (C.F.R.) Part 51c (Grants for Community Health Centers)[5], and 42 C.F.R. Part 56 (Grants for Migrant Health Services and Migrant Health Centers)[6], as applicable. Organizations must demonstrate that all program requirements are met in the application through a comprehensive program narrative, completed attachments, and forms. Organizations are encouraged to review the section 330 program requirements (available on HRSA's web site at http://bphc.hrsa.gov/about/requirements.htm), in addition to the applicable statutes, regulations, and policies (discussed in Appendix C, Resources) for FQHC Look-Alikes prior to developing an application.

Organizations that serve the general medically underserved population and/or a special population authorized under section 330 of the PHS Act (i.e., migratory and seasonal agricultural workers, homeless populations, and residents of public housing) can apply for FQHC Look-Alike designation. Organizations must demonstrate compliance with the specific requirements of each type of population served, as applicable, for HRSA to recommend FQHC Look-Alike designation to CMS. Those requesting designation/designated to serve exclusively a special population may not have more than 25% of patients from the general population.[7] Specifics regarding program requirements for the different types of populations are detailed below.

(a) Organizations Serving the General Medically Underserved Population (i.e., section 330(e) Community Health Center)

Organizations that receive FQHC Look-Alike designation and serve the general population (section 330(e)) are statutorily obligated to make services available to all residents of the service area[8] (including migratory and seasonal agricultural workers, homeless persons, and residents of public housing), to the extent possible using available resources. The application must demonstrate how the organization offers access to comprehensive, culturally competent, quality primary, preventive, and enabling health care services, including oral health, mental health and substance abuse services. Furthermore, organizations must demonstrate that the program will improve the health status of underserved and vulnerable populations in the area to be served. Organizations

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[3] FQHC Look-Alike applicants do not have to be **located in** a MUA but must **serve** in whole or in part either a MUA or MUP.

[4] Requested, not required for FQHC Look-Alikes exclusively serving Migrant, Homeless, or Public Housing populations.

[5] 42 C.F.R. Part 51c does not apply to FQHC Look-Alikes exclusively serving Homeless or Public Housing populations.

[6] 42 C.F.R. Part 56 only applies to FQHC Look-Alikes exclusively serving Migrant populations.

[7] Please Refer to PIN 2009-05, "Policy for Special Populations-Only Grantees Requesting as Change in Scope to Add a New Target Population," for HRSA's policy on target populations.

[8] Section 330(a)(1)(B) of the PHS Act.

are expected to demonstrate compliance with section 330(e) and all applicable regulations and policies.

(b) Organizations Serving a Special Population

i. Migratory and Seasonal Agricultural Workers (i.e., section 330(g) - Migrant Health Center)

Organizations that request designation to serve migratory and seasonal agricultural workers (MSAWs) must have a service delivery plan that addresses the unique health care needs of MSAWs and their families in the defined service area. Furthermore, the service delivery plan must assure the availability and accessibility of essential high quality, culturally competent primary, preventive, and enabling health care services, including oral health, mental health and substance abuse services. Organizations serving **only** section 330(g) MSAW populations may request a "good cause" exemption to: (1) waive the requirement that the center provide all required primary health services under section 330(b)(1) of the PHS Act; and (2) provide certain required primary health services only during certain periods of the year.[9]

Applications to serve MSAWs must describe: (1) the manner in which comprehensive outreach is conducted and integrated into the primary care delivery system; (2) how transportation and other enabling services are provided; (3) the manner in which case management and eligibility assistance are made available; and (4) how adjustments are made for service delivery during peak and off-season cycles. Mechanisms may include: outreach that is integrated into the primary health care delivery system; use of mobile vans or health teams that travel to migrant camps; transportation; extended clinic hours; etc. In addition, organizations must consistently monitor the special environmental and occupational health concerns that are associated with MSAWs.

Organizations that serve MSAW populations must comply with section 330(e) and section 330(g), and all applicable regulations and policies to be considered for FQHC Look-Alike designation. Organizations that serve MSAWs and their families and receive FQHC Look-Alike designation are not subject to the requirement to provide access to care for all residents of the service area; however, all FQHC Look-Alikes are expected to address the acute care needs of all who present for service regardless of residence and/or ability to pay.

ii. Homeless Populations (i.e., section 330(h) - Health Care for the Homeless)

Organizations that request designation to serve homeless populations must have a service delivery plan that addresses the unique health care needs of homeless populations in the defined service area. Furthermore, the service delivery plan must assure the availability and accessibility of essential high quality, culturally competent primary, preventative, and enabling health care services, including oral health, mental health, and substance abuse services.

[9] Section 330(b)(1)(B) of the PHS Act.

Applications to serve homeless persons must: (1) indicate the mechanism for delivering substance abuse services to homeless populations; (2) describe the manner in which comprehensive outreach is conducted and integrated into the primary care delivery system; (3) describe how transportation and other enabling services are provided; and (4) describe the manner in which case management, eligibility assistance, and access to housing services are made available to homeless patients.

Organizations that serve homeless populations must comply with section 330(e) and section 330(h), and all applicable regulations and policies to be considered for FQHC Look-Alike designation. Organizations that serve homeless populations and receive FQHC Look-Alike designation are not subject to the requirement to provide access to care for all residents of the service area; however, all FQHC Look-Alikes are expected to address the acute care needs of all who present for service regardless of residence and/or ability to pay.

iii. Residents of Public Housing (i.e., section 330(i) - Public Housing Primary Care)

Organizations that request designation to serve residents of public housing must have a service delivery plan that addresses the unique health care needs of public housing residents in the defined service area. Furthermore, the service delivery plan must assure the availability and accessibility of essential high quality, culturally competent primary, preventive, and enabling health care services, including oral health, mental health, and substance abuse services. Organizations serving residents of public housing must: (1) demonstrate that the service site(s) is immediately accessible to the targeted public housing community; and (2) have a mechanism for involving residents in the preparation of the application and in the on-going management of the Program.

Organizations that serve public housing residents must comply with section 330(e) and section 330(i), and all applicable regulations and policies to be considered for FQHC Look-Alike designation. Organizations that serve public housing residents and receive FQHC Look-Alike designation are not subject to the requirement to provide access to care for all residents of the service area; however, all FQHC Look-Alikes are expected to address the acute care needs of all who present for service regardless of residence and/or ability to pay.

iv. Requests for a Waiver of Governance Requirements[10]

Organizations that request designation to serve a special population authorized under section 330 of the PHS Act may request a waiver of certain governance requirements. Currently, HRSA will only consider a waiver of the 51 percent consumer/patient majority governance requirement and the monthly meetings governance requirement. Organizations must submit Form 6 – Part B, Request for Waiver of Governance Requirements, in the application for consideration of a governance waiver. The waiver request must include a description of the reasons for the waiver and a detailed plan regarding how the organization will comply with the intent of the section 330 governance requirements. Approved waivers will be in effect for the length of the project period.

[10] Please refer to http://www.bphc.hrsa.gov/policies for guidance on governance requirements.

FQHC Look-Alikes will need to submit a new request as part of a renewal of designation application to maintain the waiver in the new project period.

Organizations that serve the general population (i.e., section 330(e)) in conjunction with a special population (i.e., section 330(g), (h), and/or (i)) must satisfy all section 330(e) program requirements as well as the section 330 program requirements of the specific special population). Requests for waivers will not be granted for organizations that serve the general population or the general population in conjunction with a special population.

3. Public Centers[11]

Section 330 of the PHS Act and the implementing regulations[12] permit any pubic agency to apply for FQHC Look-Alike designation. Public agencies must comply with the section 330 statutory and regulatory program requirements; however, recognizing that some public agencies may not be able independently to meet all health center requirements due to operational and/or legal constraints, public agencies may comply with these requirements through a "co-applicant" arrangement. In co-applicant arrangements, the public agency receives the FQHC Look-Alike designation and the co-applicant's board serves as the health center's governing board. The public agency and the co-applicant are collectively referred to as the "health center" or "public center."

In the co-applicant arrangement, the public agency is responsible for maintaining and demonstrating compliance with all program requirements. The public agency may retain the responsibility for establishing fiscal and personnel policies;[13] however, the co-applicant governing board must meet all the size and composition requirements and perform and maintain all governance authorities, including: hold monthly meetings; select/dismiss/evaluate the CEO; approve the annual budget; select the services provided and hours of operation; and establish general policies for the FQHC Look-Alike. HRSA recommends that the co-applicant governing board be formally incorporated to ensure maximum accountability.

The public agency and the co-applicant entity must have a co-applicant agreement that describes the delegation of authority and defines each party's role, responsibilities, and authorities. The co-applicant agreement, governing board bylaws, and articles of incorporation must assure that the co-applicant governing board retains its full authorities, responsibilities, and functions, aside from those prescribed general policies that may be retained by the public agency.

Many organizations serve public interests by providing health care and other essential services to the underserved in their communities; however, not all can be classified as public agencies eligible for public center status under the FQHC Look-Alike Program. Documentation demonstrating either of the following will be used by HRSA to assess whether an organization will qualify as a "public agency" for purposes of FQHC Look-Alike designation:

[11] Please refer to http://bphc.hrsa.gov/policy/#lookalikes for information on public entities and co-applicant arrangements.
[12] 42 C.F.R. 51c.103.
[13] Section 330(k)(3)(H)(ii) of the PHS Act.

1. The Internal Revenue Service (IRS) has determined that the entity is a subdivision, municipality, or instrumentality of government that is exempt under Internal Revenue Code section 115 and the public agency has obtained a "letter ruling" (i.e., a positive written determination by the IRS of this status) by following the procedures specified in Revenue Procedure 2009-1 or its successor, as applicable. Evidence to support this determination may include an affirmation letter from the IRS or similar documentation.

   OR

2. The public agency otherwise demonstrates through supporting documentation that it meets the IRS standards that would determine that the public agency is a subdivision, municipality, or instrumentality of government that is exempt under Internal Revenue Code section 115.

The IRS Federal, State & Local Governments (FSLG) Office may provide more guidance. Its website is: http://www.irs.gov/govt/fslg/index.html. In addition, the IRS published an article on instrumentalities as part of its Exempt Organizations Continuing Professional Education (CPE) Technical Instruction Program for Fiscal Year 1990, which may provide more information on this topic. This article can be found at: http://www.irs.gov/pub/irs-tege/eotopice90.pdf.

When applying for FQHC Look-Alike designation, applicants must self-identify as a non-profit or public agency. The documentation described above will be used by HRSA to verify that an organization applying for FQHC Look-Alike designation meets the eligibility criteria to be designated as a public center.

Existing FQHC Look-Alikes that are currently self-designated as public agencies may find that their organization does not qualify for this status under these criteria. Should this occur and, consequently, the organization with its existing governing board structure no longer meets section 330 statutory and regulatory program requirements, HRSA will provide these organizations with an opportunity to develop and implement a plan to come into compliance. HRSA will work with affected FQHC Look-Alikes to address their issue(s) on a case-by-case basis.

4. Service Area Overlap

HRSA is committed to increasing access to health care services to vulnerable and underserved populations including expanding and adding new sites and services in communities with high unmet health care needs. Organizations must demonstrate there is a need for health care services in the area to support the designation of a new FQHC Look-Alike or addition of a new service delivery site for an existing FQHC Look-Alike. Organizations must demonstrate collaboration and coordination of health care services with other area health care providers including existing section 330 program grantees and/or FQHC Look-Alikes through letters of support, Memorandums of Agreement/Understanding, and/or other formal documentation. For organizations that are serving the same, or a contiguous, area served by a section 330 program grantee or FQHC Look-Alike, HRSA will conduct an analysis to determine the level of unmet need in the area to support an additional FQHC or service delivery site. HRSA's policy and process for determining service area overlap is identified in PIN 2007-09, "Service Area

Overlap: Policy and Process." Organizations are strongly encouraged to review this PIN and include appropriate documentation in its application to facilitate the review process.

III. APPLICATION SUBMSSION REQUIREMENTS

1. Types of Applications

This section details the requirements for preparing and submitting applications for the FQHC Look-Alike Program. Organizations are encouraged to review this PIN and contact HRSA with any questions prior to submitting an application. To facilitate processing and review, applicants should provide all required information in the sequence and format described in these instructions and ensure that the information and data provided in the application is accurate, up-to-date, and consistent. Refer to Appendix H for tips on how to develop a high quality application. There are four types of FQHC Look-Alike Program applications:

i. *Initial Designation* – This application type is for organizations that are seeking initial FQHC Look-Alike designation. The application must demonstrate eligibility and compliance with all requirements as identified in Section II, Eligibility and Program Requirements. Organizations are encouraged to collaborate with HRSA, their State Primary Care Association (PCA) and/or Primary Care Office (PCO), and other primary care providers in the community to prepare the application.

ii. *Renewal of Designation* – FQHC Look-Alikes are assigned a project period for which the FQHC Look-Alike designation is valid (normally five years; however, the period may vary at HRSA's discretion). FQHC Look-Alikes must submit a renewal of designation application at the end of the project period in order to maintain the FQHC Look-Alike designation status. The renewal of designation application must be submitted to HRSA at least six months prior to the end of the project period. Failure to renew the FQHC Look-Alike designation could result in termination of the FQHC Look-Alike status and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits).

iii. *Annual Recertification* – During the approved project period, FQHC Look-Alikes must submit an annual program update. The recertification application must be submitted to HRSA at least three months prior to the FQHC Look-Alike's annual designation date. Failure to recertify could result in termination of the FQHC Look-Alike status and all corresponding benefits (e.g., Medicare and Medicaid FQHC reimbursement, 340B Drug Pricing Program benefits).

iv. *Change in Scope of Project* – This application type is required for existing FQHC Look-Alikes that want to add/delete/relocate a site and/or add/delete a service to their currently approved scope of project.[14] FQHC Look-Alikes must obtain prior approval from HRSA

[14] Note: a "change in scope of project" under section 330 is not the same as "change in the scope of services" in Medicaid as defined in the Benefits Improvement and Protection Act (BIPA) of 2000, Section 702. The Centers for Medicare and Medicaid Services (CMS) and State Medicaid Agencies define the term "change in the scope of services" as a mechanism for adjusting the Medicaid reimbursement rate of an FQHC due to "a change in the type, intensity, duration and /or amount of services." A State approved "change in the scope of service" can result

to make any changes (i.e., additions/deletions/relocations) independent of a renewal of designation or annual recertification application. FQHC Look-Alikes should refer to PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes,"[15] for complete guidance on HRSA's policy regarding scope of project.

HRSA encourages FQHC Look-Alikes to submit change in scope requests at least 90 days in advance of the proposed implementation date, to the extent possible. There may be circumstances where submitting a change in scope request early may not be possible; however, the goal is to minimize these occurrences through careful planning. Timely submission of a change in scope request is important to ensure Medicare and Medicaid FQHC reimbursement and 340B Drug Pricing benefits for the specific site/service, as appropriate.

2. Where to Submit the Application

HRSA accepts initial designation and change in scope applications on a rolling basis. Renewal of designation and annual recertification applications should be submitted to HRSA in accordance with the established time frames. Failure to submit the renewal of designation, annual recertification, and/or change in scope of project application may result in a delay in recertification.

Type of Application:	**When to Submit to HRSA:**
Initial Designation	Accepted on a rolling basis throughout the year.
Renewal of Designation	At least six months prior to the end of the project period.
Annual Recertification	At least three months prior to the annual designation date.
Change in Scope of Project	At least three months prior to the proposed implementation date.

HRSA will send an acknowledgement of receipt of an application to the organization's authorized representative. Submit an original and one copy of the application to:

Health Resources and Services Administration
Bureau of Primary Health Care
ATTN: FQHC Look-Alike Program
5600 Fishers Lane, Mail Stop 17C-26
Rockville, Maryland 20857

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in an increase or decrease in FQHC Medicaid reimbursement. "Change in the scope of services" is defined differently in each State's Medicaid Plan. The State Medicaid Agency must be contacted directly if a change in scope of services is being requested by a health center. Refer to Appendix D and PIN 2008-01 for additional information regarding change in scope of project.

[15] The procedures for requesting a change in scope of project as outlined in PIN 2008-01 are applicable specifically to section 330-funded health centers; however, the policies regarding scope of project and HRSA's expectations are applicable to FQHC Look-Alikes. Information that is specific to section 330-funded health centers (e.g., Federal Torts Claims Act, Accreditation, grant funding related policies, etc.) are not applicable to FQHC Look-Alikes.

3. Application Content and Format

Each application type has specific required and optional components of the application, which is outlined in the schematic below. All **required** information is denoted by the symbol "●." Areas in the schematic that are denoted by the symbol "✻" indicate that the document is optional based on the nature of the application and as described by the "NOTE" in the instructions column. All blank fields indicate the document is not included in that particular application type. Organizations are encouraged to review this schematic prior to submitting an application to ensure that all required components are included. Failure to submit all required components as outlined in this schematic may result in a delay of HRSA's application review. (Column "ID" – Initial Designation; Column "RD" – Renewal of Designation; Column "AR" – Annual Recertification; Column "CS" – Change in Scope.)

Application Content	Instructions	Required for Application?			
		ID	RD	AR	CS
Form 1 – Part A: General Information Worksheet	Refer to Appendix I for instructions on completing this Form. **NOTE**: Form 1 – Part A must be notarized and signed by the organization's authorized representative (i.e., Board Chair or Executive Director).	●	●	●	●
Table of Contents	Prepare a table of contents reflecting major headings, including subheadings and appendices, with page numbers.	●	●	●	●
Project Abstract	The project abstract should be single-spaced, limited to two pages in length, and provide a brief description of the project including the needs addressed, the services provided, the population group(s) served, and a summary of the organizational structure. Please prepare the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. The abstract narrative should include: – A brief history of the organization, the community served and the target population(s). – A summary of the major health care needs and barriers to care. – A summary of the number of providers, service delivery locations, services, and total number of patients and visits. – A brief description of any other relevant information.	●	●	●	●
Project Narrative	Refer to the following pages for each application type: 1. Initial Designation – page 23 2. Renewal of Designation – page 23 3. Annual Recertification – page 37 4. Change in Scope – page 43	●	●	●	●
Health Care Plan	Refer to Appendix E for instructions on completing the Health Care Plan.	●	●	●	
Business Plan	Refer to Appendix E for instructions on completing the Business Plan.	●	●	●	
Form 1 – Part C: Documents on File	Refer to Appendix I for instructions on completing this Form.	●	●	●	
Form 2: Staffing Profile	Refer to Appendix I for instructions on completing this Form.	●	●	●	
Form 3: Income	Refer to Appendix I for instructions on completing this Form.	●	●	●	●

Application Content	Instructions	Required for Application?			
		ID	RD	AR	CS
Analysis Form					
Form 4: Community Characteristics	Refer to Appendix I for instructions on completing this Form.	●	●	●	●
Form 5 - Part A: Services Provided	Refer to Appendix I for instructions on completing this Form. **NOTE**: FQHC Look-Alikes should only identify the existing services in the approved scope of project (excluding pending applications for change in scope to add a service).	●	●	●	●
Form 5 - Part B: Service Sites	Refer to Appendix I for instructions on completing this Form. **NOTE**: FQHC Look-Alikes should only identify the existing service sites in the approved scope of project (excluding pending applications for change in scope to add a site).	●	●	●	●
Form 5 - Part C: Other Activities/Locations (if applicable)	Refer to Appendix I for instructions on completing this Form. **NOTE**: FQHC Look-Alikes should only identify other activities/locations in the approved scope of project. Changes in Other Activities/Locations do not require a prior approval from HRSA (i.e., change in scope application); however, organizations should submit a revised Form 5 – Part C when changes are made.	●	●	●	✻
Form 6 - Part A: Current Board Member Characteristics	Refer to Appendix I for instructions on completing this Form.	●	●	●	
Form 6 - Part B: Request for Waiver of Governance Requirements	Refer to Appendix I for instructions on completing this Form. **NOTE**: Only organizations that request designation exclusively to serve a special population authorized under section 330 of the PHS Act are eligible for a governance waiver. FQHC Look-Alikes with an approved waiver must request to maintain the waiver in the renewal of designation application.	●	●		
Form 8: Health Center Affiliation Certification and Checklist	Refer to Appendix I for instructions on completing this Form. **NOTE**: Form 8 is approved for the length of the project period; FQHC Look-Alikes should submit a Form 8 in the annual recertification application only if there is a new or changed affiliation agreement.	●	●	✻	●
Form 10: Annual Emergency Preparedness and Management Report	Refer to Appendix I for instructions on completing this Form.	●	●	●	
Form 12: Contacts Information	Refer to Appendix I for instructions on completing this Form.	●	●	●	●
Electronic Health Record	Refer to Appendix I for instructions on completing this information.	●	●	●	●
Table 3A and 3B: Patients by Age, Gender, Ethnicity, Race and Language	Refer to Appendix I for instructions on completing this Table.	●	●	●	●
Table 4: Selected Patient	Refer to Appendix I for instructions on completing this Table.	●	●	●	●

Application Content	Instructions	Required for Application?			
		ID	RD	AR	CS
Characteristics					
Table 5: Staffing and Utilization	Refer to Appendix I for instructions on completing this Table.	●	●	●	●
Attachment 1: Patient Origin Study	The patient origin study should identify the number of patients residing in each zip code served by the organization (e.g., ZIP Code 29999 = 48 patients; ZIP Code 29994 = 134 patients). Organizations may submit this information in a table format starting with the zip code with the greatest patients served. **NOTE**: Organizations requesting to add a site to the scope of project must submit a patient origin study if the information is available (i.e., the site is operational). The study is not needed if the organization is only proposing to add a service.	●	●	●	●
Attachment 2: Service Area Map	Provide a map that clearly identifies the areas served by the organization, all service delivery sites, the designated MUA/MUP areas, census tracts, zip codes, and the location of other primary care provider sites (e.g., section 330-funded health centers, FQHC Look-Alikes, hospitals, free-clinics, etc.). Organizations are encouraged to use HRSA's Geospatial Data Warehouse mapping feature to produce maps. This feature is available on HRSA's web site at http://datawarehouse.hrsa.gov/.	●	●	●	●
Attachment 3: Current or requested MUA/MUP designation	Provide a dated copy of the current or requested MUA/MUP designation. For inquiries regarding MUA/MUP, call 1-888-275-4772 (press option 1, then option 2); contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816; or obtain additional information on HRSA's web site at http://bhpr.hrsa.gov/shortage/. Organizations may submit as documentation of the MUA/MUP designation a confirmation page from HRSA's "Find Shortage Areas" web site.	●	●		
Attachment 4: Governing Board Bylaws	Provide a signed and dated copy of the governing board bylaws. The bylaws must demonstrate compliance with the requirements of section 330 of the PHS Act, 42 C.F.R. 51c, and 42 C.F.R. 56 (as applicable). **NOTE**: Applications for annual recertification should include a copy of the bylaws only if there have been any amendments.	●	●	✻	
Attachment 5: Governing Board Meeting Minutes	Submit a copy of the meeting minutes that document the governing board's approval of the FQHC Look-Alike application submission. Include any additional meeting minutes that demonstrate the governing board's participation in the development of the application. Organizations that are requesting a change in scope to add a site or service should include copies of the board meeting minutes to document the board's approval of the request.	●	●	●	●
Attachment 6: Co-Applicant Agreement for Public Centers (if applicable)	Public centers with a co-applicant arrangement must provide a signed and dated copy of the written agreement between the two parties. The co-applicant agreement must identify the roles and responsibilities of both the public center and co-applicant, the delegation of authorities of both parties, and any shared roles and responsibilities in carrying out the governance	●	●	✻	

Application Content	Instructions	Required for Application?			
		ID	RD	AR	CS
	functions. **NOTE**: Applications for annual recertification should submit a copy of the agreement only if any changes have been made during the period.				
Attachment 7: Affiliation, Contract, and/or Referral Agreements (if applicable)	Provide any documents that describe working relationships between the organization and other entities cited in the application (e.g., contracted provider and/or staff, management services contracts, etc.). Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any deliverables. All contracts and/or letters of agreement must identify the time period during which the agreement is effective, the specific services covered, any special conditions under which the services are to be provided, and the terms for billing and payment. All copies must be legible, and signed and dated by both parties. Organizations that do not have contractual agreements with another entity should clearly indicate so in the narrative. As a reminder, contracts must be in compliance with section 330 of the PHS Act and 42 C.F.R. 51c. In addition, the governing board must approve all contracts and retain authority over the organization's policy and procedures, such as budget, hours, and services provided. **NOTE**: Applications for annual recertification, or change in scope should submit a copy of any new agreements or amended agreements.	●	●	✻	✻
Attachment 8: Articles of Incorporation	Private, non-profit organizations must provide a copy of the Articles of Incorporation filed with the State or other evidence of non-profit status (e.g., a letter from the State or the Federal government or evidence that an application for non-profit status has been submitted). The seal page documenting the State acceptance of the articles must be included with the application. **NOTE**: Applications for renewal of designation or annual recertification should submit a copy of the Articles of Incorporation only if any changes have occurred to the document.	●	●	✻	
Attachment 9: IRS Tax Exempt Certification	Private, non-profit organizations must provide evidence of current or pending tax exempt status. Public centers must provide evidence of the co-applicant governing board's current or pending tax exempt status if the co-applicant is independently incorporated. Any of the following is acceptable evidence: – A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations, described in section 501(c)(3) of the IRS Code. – A copy of a currently valid IRS tax exemption certificate. – A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals. – A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes	●	●		

Application Content	Instructions	Required for Application?			
		ID	RD	AR	CS
	the nonprofit status of the organization.				
Attachment 10: Medicare and Medicaid Provider Documentation	Submit a copy of the CMS notification that documents the organization is an approved Medicare and Medicaid provider and the provider numbers.	●	●		
Attachment 11: Organizational Chart	Provide an organizational chart showing the organizational and management structure and lines of authority, key employee position titles, names, and Full Time Equivalents (FTEs). The governing board and individuals with the following responsibilities should be clearly identified: CEO/Executive Director, Chief Medical Officer (CMO)/Clinical Director, and Chief Financial Officer (CFO)/Financial Manager. The chart should demonstrate the governing board retains ultimate authority and leadership of the organization. Public centers with co-applicant arrangements should demonstrate the relationship between the two entities.	●	●	●	●
Attachment 12: Position Descriptions for Key Personnel	Submit a copy of position descriptions for all key management positions. Indicate on the position descriptions if key management positions are combined and/or part-time (e.g., CFO and Chief Operation Officer (COO) roles are shared). At minimum, the position description should include the position title, description of duties and responsibilities, position qualifications, supervisory relationships, skills, knowledge and experience requirements, travel requirements, salary range and hours worked. **NOTE**: Applications for annual recertification and change in scope should submit a copy of position descriptions for any new positions or any amended positions.	●	●	✻	✻
Attachment 13: Resumes for Key Personnel	Provide resumes of key personnel for the organization. In the event that a resume is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the resume. **NOTE**: Applications for annual recertification and change in scope should submit a copy of resumes for any new key personnel.	●	●	✻	✻
Attachment 14: Schedule of Discounts/Sliding Fee Scale	Provide a schedule of charges with a corresponding schedule of discounts for which charges are adjusted on the basis of the patient's ability to pay. Organizations must show sliding fee scale discounts for persons with incomes between 200% and 100% of the most current annual Federal poverty guidelines (FPG) (see the most current annual FPG at http://aspe.hhs.gov/poverty/). Patients with incomes below 100 percent of the FPG may not be charged for services (nominal fees are acceptable if they do not serve as barriers to obtaining services). No discounts may be accorded to patients with incomes over 200% of the FPG.	●	●		
Attachment 15: Most Recent Independent Financial Audit	Submit a complete copy of the organization's most recent annual audit, including the auditor's opinion statement (i.e., management letter). Audit information will be considered complete when it includes the balance sheet, profit and loss statement, audit findings, management letter and any noted	●	●	●	

Application Content	Instructions	Required for Application?			
		ID	RD	AR	CS
	exceptions. The audit must comply with generally accepted accounting principles (GAAP). In instances where the audit is not available at the time of application submission, identify the anticipated time frame for completion of the auditor report and submit a copy of the organization's most recent six months of financial statements.				
Attachment 16: Letters of Support	Organizations are strongly encouraged to collaborate with other primary care providers in the community including section 330 funded health centers, FQHC Look-Alikes, State agencies, social service organizations, and associations (e.g., PCAs). Include a copy of any letters from the other primary care providers in the area that support the organization's request for FQHC Look-Alike designation or change in scope request to add a site/service, or an explanation of why the organization was unable to obtain the support letter. **NOTE**: Applications for annual recertification should submit copies of any letters of support from newly established partnerships.	●	●	❋	●
Attachment 17: Other Information	Organizations may include other relevant documents to support the proposed project plan such as charts and organizational brochures. Organizations should attach floor plans and lease/intent to lease documents for any facilities.	●	●	❋	❋

4. Initial Designation and Renewal of Designation Applications

This section provides additional instructions for organizations applying for initial designation and renewal of designation. Organizations applying for renewal of designation should pay particular attention to the "NOTES" throughout the program narrative, which identify additional/specific guidance for existing FQHC Look-Alikes.

The program narrative should be a detailed picture of the community/target population served, the organizational structure, and how the organization is addressing the identified health care needs of the community. Organizations must respond to all criteria and submit all applicable forms and attachments (as identified in Section III.3., Application Contents and Format, column "ID" for initial designation and column "RD" for renewal of designation) to demonstrate compliance with program requirements. Failure to include all required information could result in a delay of HRSA's review.

Applicants should fully address ALL requirements within the narrative component of the application. All documents (i.e., program narrative, forms, and attachments) are evaluated collectively.

Criterion 1: Need

1. Identify the geographic boundaries of the areas served by the organization (i.e., the names of counties, localities, zip codes, and census tracts). Identify the MUA/MUP and HPSAs served. Discuss any geographic barriers related to accessing primary health care services. The narrative must align with the map provided in the application.

2. Based on the organization's most recent needs assessment and other available data, including MUA/MUP designations for organizations serving the general community (section 330(e) of the PHS Act), identify the most relevant factors impacting access to care and unmet need for primary care in the target population served. Information provided on need should serve as the basis for, and align with, the activities and goals described in the Health Care Plan, Business Plan, and throughout the application.

   Data provided should not be based on the current patient population but rather on the total stated target population in the area served, including special populations, if applicable. In some cases, it may be difficult to find data specific to the service area or target population to effectively describe the level of need, especially for organizations serving only special populations. In such situations, organizations may extrapolate from data available at higher levels to estimate the correct value in the service area or target population, including national data sources.

   Responses to all indicators must be expressed in the same format/unit of analysis identified in the specific barrier or health indicator (e.g., a mortality ratio can not be used to provide a response to "age-adjusted death rate"). The following table provides examples of the unit and format of responses:

Format/Unit of Analysis	Example
Percent	25% (25 percent of target population is uninsured)
Prevalence (expressed as percent or rate)	8.5% (8.5 percent of population has asthma) **or** 85 per 1,000 (85 asthma cases per 1,000 population)
Proportion	0.25 (25 out of 100 people, or 25% of all persons, are obese)
Rate	50 per 100,000 (50 hospital admissions for hypertension per 100,000 population)
Ratio	3000:1 (3000 people per every 1 primary care physician)

Please note that HRSA has developed a Data Resource Guide to assist communities in identifying their unique health disparities and other factors impacting access to care for their communities, available at http://bphc.hrsa.gov/needforassistance/dataresourceguide.htm. While data sources are provided in the Data Resource Guide for all barrier and disparity indicators, organizations may use alternate, reliable data sources to develop their responses.

(a) Respond to three out of the following four barriers. All responses must be expressed in the unit and format requested. Briefly describe in two to three sentences the context and relationship of these barriers to primary health care access for the target population within the service area.
   i. Population to one FTE primary care physician ratio.
   ii. Percent of population with annual incomes at or below 200 percent of the FPG.
   iii. Percent of population uninsured.
   iv. Distance (miles) or travel time (minutes) to nearest primary care provider accepting new Medicaid patients and/or uninsured patients.

(b) Respond to one core health indicator from within each of the six categories below: Diabetes/Obesity, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health, and Behavioral and Oral Health. All responses must be expressed in the unit and format requested. Provide the current value for the target population within the service area for each response. Organizations may elect to use an "Other" alternative for that core health indicator category if none of the specified indicators represent the area or target population served by the organization. If providing an "Other" category indicator, specify the indicator's definition, data source used, proposed benchmark to be used, source of the benchmark, and rationale for using this alternative category indicator. Briefly describe in one to two paragraphs the context and relationship of selected indicators to the health status of the target population within the service area.

CORE HEALTH INDICATOR CATEGORIES

Diabetes, Obesity (Pick 1)
(a) Diabetes short-term complication hospital admission rate

Diabetes, Obesity (Pick 1)
(b) Diabetes long-term complication hospital admission rate
(c) Uncontrolled diabetes hospital admission rate
(d) Rate of lower-extremity amputation among patients with diabetes
(e) Age adjusted diabetes prevalence
(f) Adult obesity prevalence
(g) Diabetes mortality rate – (Number of deaths per 100,000 reported as due to diabetes as the underlying cause or as one of multiple causes of death (ICD-9 Code 250))
(h) Other

Cardiovascular Disease (Pick 1)
(a) Hypertension hospital admission rate
(b) Congestive heart failure hospital admission rate
(c) Angina without procedure hospital admission rate
(d) Mortality from diseases of the heart - [number of deaths per 100,000 reported as due to heart disease (includes ICD-9 codes I00-I09, I11, I13, and I20-I51)]
(e) Proportion of adults reporting diagnosis of high blood pressure
(f) Other

Cancer (Pick 1)
(a) Cancer screening – percent of women 18 and older with no pap test in past 3 years
(b) Cancer screening – percent of women 40 and older with no mammogram in past 3 years
(c) Cancer screening – percent of adult 50 and older with no fecal occult blood test within the past 2 years
(d) Other

Prenatal and Perinatal Health (Pick 1)
(a) Low birth weight rate, 5 year average
(b) Infant mortality rate, 5 year average
(c) Births to teenage mothers (15-19 years old) (percent of all births)
(d) Late entry into prenatal care (entry after first trimester) (percent of all births)
(e) Cigarette use during pregnancy (percent of all pregnancies)
(f) Other

Child Health (Pick 1)
(a) Pediatric asthma hospital admission rate

Child Health (Pick 1)
(b) Percent of children not tested for elevated blood lead levels by 36 months of age
(c) Percent of children not receiving recommended immunizations 4-3-1-3-3 (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B)
(d) Other

Behavioral and Oral Health (Pick 1)
(a) Depression prevalence
(b) Suicide rate
(c) Youth suicide attempts requiring medical attention (percent of all youth)
(d) Percent of adults with mental disorders not receiving treatment
(e) Any illicit drug use in the past month (percent of all adults)
(f) Heavy alcohol use (percent among population 12 and over)
(g) Homeless with severe mental illness (percent of all homeless)
(h) Oral health (percent without dental visit in last year)
(i) Other

(c) Respond to two out of the 12 health indicators listed below. All responses must be expressed in the unit and format requested. If providing an "Other" indicator, specify the indicator definition, data source used, proposed benchmark to be used, source of the benchmark, and rationale for using this alternative indicator. Briefly describe in one to two paragraphs the context and relationship of selected factors to the health status of the target population within the service area.

OTHER HEALTH INDICATORS (Pick 2)
(a) Age-adjusted death rate
(b) HIV infection prevalence
(c) Percent elderly (65 and older)
(d) Adult asthma hospital admission rate
(e) Chronic obstructive pulmonary disease hospital admission rate
(f) Bacterial pneumonia hospital admission rate
(g) Three year average pneumonia death rate (three year average number of deaths per 100,000 due to pneumonia (includes ICD – 9 codes 480-486))
(h) Adult current asthma prevalence
(i) Adult ever told had asthma (percent of all adults)
(j) Unintentional injury death rate
(k) Percent of population linguistically isolated (percent of people 5 years and over who speak a language other than English at home)
(l) Waiting time for public housing where public housing exists

OTHER HEALTH INDICATORS (Pick 2)
(m)Other
(n) Other

3. Provide a description of the unique characteristics of the target population within the service area that impact access to primary health care, health care utilization, and/or health status. This section should not restate items previously cited in question #2, but rather describe additional aspects of need that are not captured by quantitative data. Information provided on need should serve as the basis for, and align with, the goals described in the Health Care Plan, Business Plan, and throughout the application. Organizations should reference Form 4, Community Characteristics, and Attachment 2, Service Area Map. Include a description of:
   (a) The unserved and underserved populations in the community.
   (b) The unique demographic characteristics of the target population (age, gender, insurance status, unemployment, poverty level, ethnicity/culture, education, health language, beliefs, etc.).
   (c) The extent to which the target population currently has access to primary care services, including geographical and/or transportation barriers.
   (d) Any unique health care needs of the population not previously addressed.

4. Organizations requesting designation to serve a special population authorized under section 330 of the PHS Act must provide the following information, as applicable. In responding to any of these areas, discuss if there have been significant increases or decreases in these special populations in the service area (e.g., large groups of migrant workers no longer work in the service area). Information provided on need should serve as the basis for, and align with, the goals described in the Health Care and Business Plans and the information provided throughout the application.
   (a) Migratory and Seasonal Agricultural Workers (section 330(g) of the PHS Act) – Describe the factors (access barriers, past utilization, etc.) related to the health care needs and demand for services of MSAWs, including a description of:
      i. Agricultural environment (crops and growing seasons, need for hand labor, number of temporary workers, etc.);
      ii. Approximate period(s) of residence of all groups of migratory workers and their families; and
      iii. Occupation-related factors (working hours, housing, sanitation, hazards including pesticides and other chemical exposures, etc.).
   (b) People Experiencing Homelessness (section 330(h) of the PHS Act) – Describe the specific health care needs and access issues impacting persons experiencing homelessness (number of providers treating homeless individuals, availability of homeless shelters and/or affordable housing, etc.).
   (c) Residents of Public Housing (section 330(i) of the PHS Act) – Describe the health care needs and access issues impacting residents of public housing (availability of public housing, impact on the residents in the targeted public housing communities served, etc.).

5. Describe the health care environment and identify any significant changes that have affected the organization's ability to provide services and/or have affected the organization's fiscal stability. Organizations should provide information on the following:
   (a) The implementation of Medicaid 1115 or 1915(b) waivers; changes in SCHIP coverage; shifts or changes in State Medicaid PPS, Medicaid managed care, Medicare, and current or proposed changes in State or Federal legislation (welfare or immigration reform initiatives, etc.).
   (b) Major events including changes in the economic or demographic environment of the service area (influx of refugee population, closing of local hospitals, community health care providers or major local employers, major emergencies such as hurricanes, flooding, terrorism, etc.).
   (c) If applicable, discuss the impact of any significant changes affecting the special populations served (i.e., MSAWs, homeless, and residents of public housing).

6. Describe the major gaps or duplications in primary and preventive care services (including mental health/substance abuse and oral health) in the service area (e.g., willingness of other providers to accept Medicaid or uninsured patients, provider shortages, role of any other providers who currently serve the target population).

Criterion 2: Response

1. Briefly describe how the community's needs (as described in the Need criterion) and related performance trends (Health Care and Business Plan progress, patient satisfaction findings, etc.) are incorporated in the organization's ongoing strategic planning process.

   NOTE: Applications for renewal of FQHC Look-Alike designation should discuss any significant changes in the organization's short- and long-term strategic plans and how any relevant community needs and identified performance trends (Health Care and Business Plan measures, patients satisfaction findings, etc.) have been used to inform this process. Identify any milestones or key accomplishments as well as any challenges encountered and how they were addressed

2. Provide a narrative summary of Table 3A and 3B, Patients by Age, Gender, Race, Ethnicity, and Language. Identify the total number of patients and total number of visits for the most recent 12-month period as well as the major health needs and economic status of the current patient population. The time period which the data covers must be identified on Table 3A/3B and in the narrative.

3. Describe how the following primary health services are provided including how they are made available and accessible to all life cycles without regard to ability to pay. Responses to this section should be consistent with the services identified on Form 5 – Part A, Services Provided.

(a) The provision of required primary health care services,[16] including whether these are provided directly, by contract, and/or referral.
(b) Any arrangements for mental health/substance abuse services, including whether these are provided directly, by contract, and/or referral. Organizations requesting designation to serve homeless individuals (section 330(h) of the PHS Act) must describe how substance abuse services are made available as part of the required services.
(c) Any arrangements for oral health care services, including whether these are provided directly, by contract, and/or referral.
(d) How services are culturally and linguistically appropriate (availability of interpreter/translator services, bilingual/multicultural staff, training opportunities, etc.).
(e) How enabling services, including outreach and transportation, are integrated into the primary health care delivery system. Organizations requesting designation to serve a special population authorized under section 330 of the PHS Act should specifically address how their outreach program increases access for that population(s).

4. Describe how services are delivered to the target population. The service delivery model must be appropriate for and responsive to the identified needs of the community/population served, and all sites and activities described must be consistent with those listed in Form 5 – Part B, Service Sites, and Form 5 – Part C, Other Activities/Locations. Organizations requesting designation to serve a special population authorized under section 330 of the PHS Act must demonstrate how its service delivery plan meets all applicable statutory requirements. Include the following information in the narrative:
   (a) Location(s) or setting(s) where services and other activities are provided (e.g., freestanding, single or multi-site, mobile site, seasonal site, intermittent site, school-based location, or combination), how the services are provided (i.e., direct, referral, or contract), and how other activities are integral to the service delivery.
   (b) How the facility(ies) is appropriate for service delivery. If the facility(ies) is not currently owned or under a lease agreement, provide a summary of relevant contracts and/or MOA/MOU (e.g., with a homeless shelter, public housing authority, or other partner organization) detailing how access to the facility(ies) and on-site space is assured. Include a signed and dated copy of the lease agreement and floor plan in Attachment 17.
   (c) Days and hours of operation, including mechanisms for ensuring professional coverage (i.e., direct access to a medical provider) during hours when the organization is closed.
   (d) The case management system, including arrangements for referrals, hospital admissions, discharge planning, and patient tracking.

5. Describe the charge schedule and plans that assure services are made available to all persons in the service area regardless of their ability to pay. Demonstrate how the established charge schedule is consistent with locally prevailing rates or charges, is

[16] As defined in Appendix B: Glossary.

designed to cover the reasonable costs of operation for services, and how its corresponding schedule of discounts (often referred to as a sliding fee scale) ensures that no patient will be denied services due their inability to pay. Organizations should include a description of:

(a) How often the governing board reviews and updates the organization's fee and discount schedule.
(b) How patients are made aware of the availability of the discount.

NOTE: Ability to pay is determined by a patient's annual income and family size according to the most current annual FPG for the contiguous 48 states, Alaska and wHawaii. (The most current annual FPG is available on the HHS Web site at http://aspe.hhs.gov/poverty/). Organizations must assure that no patient is denied health care services due to his/her inability to pay. Regulations require that the schedule of discounts must:

- Be available for all individuals and families with an annual income at or below 200% of the FPG.
- Provide for a full (100%) discount for all individuals and families with an annual income at or below 100% of the FPG. Nominal fees are acceptable if they do not serve as barriers to obtaining services.
- For individuals and families with incomes between 100% and 200% of the FPG, fees must be charged in accordance with a sliding discount policy based on family size and income.
- No discounts may be accorded to patients with incomes over 200% of the FPG.

6. Describe the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s). Information provided should be consistent with the Health Care Plan and Business Plan. Discuss how the QI/QA and risk management plan(s) address the following areas:
   (a) How often are assessments conducted (assessments of the appropriateness of service utilization, quality of services delivered, and/or the health status/outcomes of patients, etc.).
   (b) The person(s) responsible for conducting such assessments. These should be conducted by physicians or by other licensed health professionals under the supervision of physicians.
   (c) Methods for measuring and evaluating patient satisfaction.
   (d) The type of clinical information systems (if any) in place for tracking, analyzing, and reporting key performance data related to the plan.
   (e) How findings of the process are used to improve organizational performance.

7. Describe the governing board approved policies and procedures related to:
   (a) Current clinical standards of care.
   (b) Provider credentials and privileges.
   (c) Risk management procedures.
   (d) Patient grievance procedures.
   (e) Incident management.
   (f) Confidentiality of patient records.

8. Discuss any proposed changes in service delivery locations, services, provider types, and/or hours of operation based on the organization's on-going strategic planning. **NOTE**: HRSA's recommendation for initial or renewal of designation does not include approval of any potential changes in the future. FQHC Look-Alikes must submit a change in scope application for any proposed changes, and must receive HRSA's approval prior to implementing the change in order for it to be included in the scope of project.

Criterion 3: Evaluative Measures

Information provided on need should serve as the basis for, and align with, the activities and goals described in the Health Care and Business Plans and throughout the application. (See Guidelines for developing the Health Care and Business Plan in Appendix E.) It is suggested that the Health Care and Business Plan Tables not exceed 15 pages.

1. Summarize the Health Care Plan goals and demonstrate the goals and baselines (if baselines are not yet available, state when the data will be available) are responsive to the health needs identified in the application. The Health Care Plan and narrative should demonstrate the following:
   (a) Goals that work towards improving quality of care, health outcomes and eliminating health disparities in the areas of Diabetes/Obesity, Cardiovascular Disease, Cancer, Prenatal and Perinatal Health, Child Health and Behavioral and Oral Health. Organizations may (but are not required to) include goals that address any other key health needs within their community, target population(s), and/or for key life cycle groups (adolescents, elderly, etc.).
   (b) For organization requesting designation to serve MSAWs, homeless populations, and/or residents of public housing: appropriate goals relevant to the needs of these populations.
   (c) Goals that address the key needs of any unique populations, health issues, or lifecycles served/addressed by the organization.
   (d) Appropriate performance measures for all goals and related data collection methodology to report on such measures.
   (e) An adequate summary of the key factors that the organization anticipates contributing to or restricting progress on the stated Health Care Plan goals and any major planned responses to these factors. **NOTE:** In discussing responses to anticipated contributing or restricting factors, organizations should discuss this area broadly and do not need to provide detail at an "action step" level.

2. Summarize the Business Plan goals and demonstrate the goals and baselines (if baselines are not yet available, state when the data will be available) are responsive to the organizational and strategic planning needs identified in the application. The Business Plan and narrative should demonstrate the following:
   (a) Goals that work towards improving the organization's status in terms of Costs and Financial Viability.

(b) Appropriate performance measures for all goals and related data collection methodology to report on such measures.
(c) An adequate summary of the key factors that the organization anticipates contributing to or restricting progress on the stated Business Plan goals and any major planned responses to these factors. **NOTE:** In discussing responses to anticipated contributing or restricting factors, organizations should discuss this area broadly and do not need to provide detail at an "action step" level.

Criterion 4: Impact

1. Describe the organization's experience and expertise in the following:
   (a) Working with the target population(s).
   (b) Addressing the target population's identified health care needs.
   (c) Developing and implementing appropriate systems and services.
   (d) Collaborating with and securing support from the local community.

   Organizations must submit letters of support, commitment, and/or investment from relevant community stakeholders (i.e., section 330 funded health centers, FQHC Look-Alikes, local hospital(s), public health department, relevant State health care associations, homeless shelters, advocacy groups, other service providers, etc.). Include letters of support in Attachment 16 and reference instances of commitment and/or investment in the narrative, as appropriate. In instances where efforts to collaborate with other providers are not successful, explain why such support can not be obtained.

   NOTE: Organizations primarily serving residents of public housing (section 330(i) of the PHS Act) must describe how residents are involved in the development of the application and administration of the program.

2. Describe both formal and informal collaboration and coordination of services with other health care providers, specifically existing section 330 funded health centers, FQHC Look-Alikes, HRSA and other federally-supported organizations including Ryan White Programs, State and local health services delivery projects, private providers and programs serving the same population(s) (social services, job training, Women, Infants and Children (WIC), coalitions, community groups, etc.). This should include a description of:
   (a) How a seamless continuum of care is assured (appropriate arrangements for discharge planning and patient tracking among providers, etc.).
   (b) Referral relationships for additional health services and specialty care and with other health care providers including one or more hospitals.
   (c) Relevant agreements with outside organizations, including contracts and/or MOA/MOUs that support the project's operation and provision of primary health care services (outreach, health education, transportation, etc.). Organizations requesting designation to serve a special population authorized under section 330 of the PHS Act must discuss any formal arrangements with other organizations that provide services or support to the special population such as Migrant

Education, Migrant Head Start, homeless shelters, etc.

(d) How all statutory and regulatory requirements and expectations of the governing board are protected, and how oversight of the services is conducted. Organizations must demonstrate compliance with the BBA requirement of not being "owned, controlled, or operated by another entity." Additional guidance regarding affiliation agreements is available in PINs 1999-09 and 1999-10.

Submit copies of all agreements for contracted services paid for by the organization. All contracts must be signed and dated by both parties and must state the time period during which the agreement is in effect, the specific services it covers, any special conditions under which the services are to be provided, the terms for billing and payment, quality improvement expectations, and record keeping and data reporting requirements. Include a copy of all contracts in Attachment 7.

Criterion 5: Resources and Capabilities

1. Describe how the organizational structure, including any affiliation arrangement(s) (as referenced in Form 8 for organizations requesting designation to serve the general community and/or MSAWs), is in accordance with section 330 program requirements and is appropriate for the operational and oversight needs of the organization. Summarize all contracts and/or other agreements (as applicable) and include a signed and dated copy of all agreements in Attachment 7.

2. Describe how lines of authority from the governing board to the CEO/Executive Director down to the management structure are maintained and are in accordance with section 330 program requirements. (Reference Attachment 4: Governing Board Bylaws; Attachment 6: Co-Applicant Agreement for Public Entities (if applicable); Attachment 7: Affiliation, Contract, and/or Referral Agreements (if applicable); and Attachment 11: Organizational Chart).

3. Describe how the key management staff (i.e., CEO, CFO, Clinical Director/CMO, Chief Information Officer (CIO), and COO, as applicable) are appropriate and adequate for the size, scope, and operational and oversight needs of the organization and are in accordance with section 330 requirements. Public centers with co-applicant arrangements must describe the management structure and the roles and responsibilities of each entity in managing organization operations.

   In instances where management positions are combined and/or part-time (e.g., CFO and COO roles are shared, or the CEO also serves as CMO or a provider), demonstrate the structure meets the management needs of the organization and does not jeopardize clinical or management operations.

   Discuss any key management staff changes in the last year, as applicable, and describe a plan for recruiting and retaining key management staff including any key management long-term vacancies. Include position descriptions that identify the roles, responsibilities, and qualifications for the CEO, CFO, CMO, CIO, and COO, as

applicable, in Attachment 12. Submit resumes for all key management staff in Attachment 13.

4. Describe the current provider staffing as identified on Form 2, Staffing Profile. Include a description of the following:
   (a) How the clinical staffing plan (e.g., number and mix of health care providers and clinical support staff, language and cultural competence) is appropriate for the level and mix of services provided.
   (b) Plans for recruiting and retaining health care providers, as appropriate, to assure adequate provider capacity for the number of patients.
   (c) The Clinical Director, his/her training and skills, his/her authorities and responsibilities, and the reporting relationship between that individual and the CEO.
   (d) If the clinical staffing plan includes contracted providers, summarize all such current contracts and include a signed and dated copy of all contracts in Attachment 7.

5. Describe the management information system in place and demonstrate that it accurately collects and organizes data for required reporting, internal monitoring, quality improvement, and the support of management decisions and planning.

6. Demonstrate the organization maintains accounting and internal control systems appropriate to the size and complexity of the organization, reflect GAAP, and separate functions appropriate to organizational size to safeguard assets and maintain financial stability. Include a description of the following:
   (a) The establishment of appropriate eligibility determination, billing, credit and collection practices, including those relevant for participation in managed care or prepaid plans. Document the policies and procedures are updated annually.
   (b) The financial information system in place for tracking, analyzing, and reporting key performance data related to the organization's financial status (e.g., revenue generation by source, aged accounts receivable by income source, debt to equity ratio, net assets, working capital, visits by payor category, etc.).
   (c) Provisions for ensuring that an annual independent financial audit is performed in accordance with Federal audit requirements[17], including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. Include a complete copy of the most recent audit report, including the management letter, in Attachment 15.

7. Provide a narrative summary of Form 3, Income Analysis, and a summary of the organization's overall financial position over the past three years. Discuss how reimbursement is maximized from third party-payors (Medicare, Medicaid, State Children's Health Insurance Plan (SCHIP), private insurance, etc.) given the patient mix and number of patients and visits.

[17] Section 330(k)(3)(D) and section 330(q) of the PHS Act.

8. Discuss the organization's emergency preparedness efforts, including the development of emergency management plans and participation or attempts to participate with State and local emergency planners. Specific goals and objectives related to emergency preparedness and management should also be addressed in the Business Plan. For any questions in Form 10, Annual Emergency Preparedness and Management Report, that are answered "no," briefly discuss why the organization does not meet the questions.

Criterion 6: Governance

1. Discuss the structure of the governing board and demonstrate it is appropriate for the needs of the organization in terms of size (i.e., number of board members) and expertise (i.e., board members have a broad range of skills in such areas as finance, legal affairs, business, health, social services).

2. Demonstrate that the signed governing board bylaws and other relevant documents (e.g., co-applicant agreement, affiliation agreement, articles of incorporation) are compliant with the requirements of section 330(k)(3)(H) of the PHS Act (42 U.S.C. 254b), as amended, and 42 C.F.R. 51c or 42 C.F.R. 56.304, as applicable.[18] Describe where and how the bylaws and other relevant documents demonstrate the organization has an independent governing board that:
   (a) Is comprised of a majority (i.e., at least 51%) of individuals (i.e., "consumers" or "patients") who receive their primary health care from the organization and who as a group, reasonably represent the individuals being served by the organization in terms of race, ethnicity, and gender. Organizations requesting designation to serve the general community in conjunction with a special population authorized under section 330 of the PHS Act should have consumer/patient representation that is reasonably reflective of the populations served. At minimum, the governing board should include at least one consumer/patient from each special population authorized under section 330 of the PHS Act. No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry (this requirement may be waived for eligible organizations as noted in Form 6-B.)
   (b) Holds monthly meetings (this requirement may be waived for eligible organizations as noted in Form 6-B).
   (c) Selects the services to be provided and the organization's hours of operation.
   (d) Approves the organization's annual budget and major resource decisions.
   (e) Selects, dismisses, and annually evaluates the performance of the CEO.
   (f) Establishes general policies for the organization, except in the case of a governing board of a public center.[19]

[18] Governance requirements do not apply to Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or an urban Indian organization under the Indian Health Care Improvement Act. Section 330(k)(3)(H) of the PHS Act.

[19] The co-applicant health center board must meet all the size and composition requirements, perform all the duties of and retain all the authorities expected of governing boards except that the public center is permitted to retain responsibility for establishing some fiscal and personnel policies for the health center. Refer to PIN 1999-09,

(g) Measures and evaluates the organization's progress in: (1) meeting annual and long-term programmatic and financial goals; and, (2) developing plans for long-range viability by engaging in strategic planning, on-going review of mission and bylaws, evaluating patient satisfaction, and monitoring assets and performance.

3. Discuss the governing board's effectiveness by describing how it:
   (a) Operates governing board committees, including the structure and responsibilities of each committee. Examples of committees discussed may include Executive, Finance, Quality Improvement, Personnel, and Planning.
   (b) Monitors and evaluates the governing board's performance (e.g., process for addressing weaknesses and challenges, communication, meeting documentation, etc.).
   (c) Provides training, development and orientation for new governing board members to ensure they have sufficient knowledge and information to make informed decisions regarding strategic direction, policies, and financial position.

4. Provide a description of provisions that prohibit conflict of interest or the appearance of conflict of interest by governing board members, employees, consultants and those who furnish goods or services to the organization. This description must be included in the governing board bylaws.

5. For organizations that have a formal affiliation agreement with another entity, describe the affiliation relationship to demonstrate compliance with PIN 1997-27 regarding the governing board selection process, composition, authorities, and committee structure.

6. For public centers, as set forth under section 330(k)(3) describe how the public center meets the governance requirements, either directly or through a co-applicant arrangement. Public centers that have a co-applicant arrangement must identify each party's role, responsibilities and authorities for executing the FQHC Look-Alike. Include a signed (by both parties) and dated copy of the co-applicant agreement in the application as Attachment 6.

7. Organizations requesting a new waiver (or to continue an existing waiver) of the governance requirements as noted in Form 6 – Part B must clearly describe why the organization can not meet the statutory requirements requested to be waived and identify appropriate alternative strategies of how the organization intends to ensure consumer/patient participation (if board is not 51% consumers/patients) and/or regular oversight (if no monthly meetings) in the on-going governance of the organization. Respond to the following, as applicable:
   (a) If the consumer/patient majority is requested to be waived, discuss why the organization can not meet this requirement and describe the alternative

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"Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Public Entities."

mechanism(s) for gathering consumer/patient input (separate advisory boards, patient surveys, focus groups, etc.). Areas of discussion may include:

i. Specifics on the type of consumer/patient input to be collected.
ii. Methods for documenting such input in writing.
iii. Process for formally communicating the input directly to the organization's governing board (quarterly presentations of the advisory group to the full board, quarterly summary reports from consumer/patient surveys, etc.).
iv. Specifics on how the consumer/patient input will be used by the governing board in such areas as: (1) selecting services; (2) setting operating hours; (3) defining budget priorities; (4) evaluating the organizations progress in meeting goals, including patient satisfaction; and (5) other relevant areas of governance that requires and benefits from consumer/patient input.

(b) If monthly meetings are requested to be waived, discuss why the organization can not meet this requirement and describe the proposed alternative schedule of meeting and how the alternative schedule will assure that the governing board can still maintain appropriate oversight.

NOTE: Only organizations requesting FQHC Look-Alike designation to serve exclusively a special population authorized under section 330 of the PHS Act may request a waiver of these two governance requirements – the 51% consumer/patient majority and/or monthly meetings. Organizations must complete Form 6 – Part B to request the waiver. Furthermore, FQHC Look-Alikes with an existing waiver must submit Form 6 – Part B to maintain the waiver. An approved waiver does not relieve the organization's governing board from fulfilling all other section 330 governance requirements.

5. Annual Recertification Application

Applications for annual recertification must include all required information as identified in Section III.3., Application Contents and Format, column "AR." The specific responses to the program narrative are identified below.

The program narrative update should address broad issues and changes that have impacted the community/target population(s) served and the organization, the extent to which the organization's project plan continues to address the specific program requirements and the organizations progress in meeting the goals of the project plan as stated in the most recently approved FQHC Look-Alike designation application.

FQHC Look-Alikes should ensure that an update is provided for any changes to the elements presented in the criteria, including all appropriate health center type-specific elements. FQHC Look-Alikes are not expected to provide detailed information for each element if no changes have occurred since the last annual recertification application. Failure to clearly address the requested information could result in a delay of HRSA's review.

The following provides a framework for the program narrative update. It should be succinct, self-explanatory and well organized so that HRSA can fully understand the project. The program narrative update should be consistent with the information presented in the Health Care

and Business Plan update. Throughout the program narrative update, references may be made to exhibits and charts, as needed, in order to reflect information about multiple sites and/or geographic or demographic data. These exhibits and charts should be included as an attachment.

The program narrative update should address significant changes in the following areas:

Criterion 1: Need

1. Describe any significant changes that have occurred over the past year in the health care environment that has affected the community's ability to provide services, if applicable. Topics to be addressed may include:
   (a) Any significant changes in the implementation of Medicaid 115 or 1915(b) waivers, CHIP coverage, State Medicaid PPS, Medicaid managed care, Medicare, and/or current or proposed changes in State or National legislation (welfare or immigration reform initiatives, etc.).
   (b) Major events including any significant changes in the economic and/or demographic environment of the service area that may have resulted in a change in service area or target population (influx of refugee population; closing of local hospitals, other community health care providers, or major local employers; and, major emergencies such as hurricane, flooding, terrorism, etc.).
   (c) Any significant changes in the unique health care needs of the target population(s). FQHC Look-Alikes that are not designated to serve migratory and seasonal agricultural workers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330(i)), but currently serves or may serve these populations in the future are encouraged to discuss the unique health care needs of these populations as well.

2. FQHC Look-Alikes designated to serve one or more of the following special populations authorized under section 330 of the PHS Act must describe any significant changes to that population in the service area.
   (a) Migratory and Seasonal Agricultural Workers (section 330(g)): Describe any significant changes in the factors (e.g., access barriers, past utilization) related to the health care needs and demand for services of migratory and seasonal agricultural workers, including:
      - Agricultural environment (e.g., crops and growing seasons, need for hand labor, number of temporary workers);
      - Approximate period(s) of residence of all groups of migratory workers and their families; and/or
      - Migrant occupation-related factors (e.g., working hours, housing, sanitation, hazards including pesticides, and other chemical exposures).
   (b) People Experiencing Homelessness (section 330(h)): Describe any significant changes in the specific health care needs and access issues impacting persons experiencing homelessness (number of providers treating homeless individuals, availability of homeless shelters, and/or affordable housing, etc.).

(c) Residents of Public Housing (section 330(i)): Describe any significant changes in the health care needs and access issues impacting residents of public housing (e.g., availability of public housing).

Criterion 2: Response

1. Discuss any significant changes in the FQHC Look-Alike's short- and long-term strategic plans and how any relevant community needs as well as data from performance trends (Health Care and Business Plan measures, patient satisfaction findings, etc.) have been used to inform this process.

2. Describe responses (if applicable) to issues described in the Needs section and the reasons for any significant changes that have been implemented during the current project period related to services, providers and/or reimbursement. If the changes are a result of an approved change in scope application during the project period, please include the date when the change in scope was approved (identified in the CMS approval letter). Reference and/or incorporate relevant changes into the Health Care Plan, as applicable. Specifically address reasons for/results of any significant changes in the:
   (a) Hours of operation and locations where services are provided. (All sites and activities described should be consistent with those listed in Form 5B and Form 5C.)
   (b) Services provided including required primary health care services, behavioral health and substance abuse, oral health, and/or enabling services and how they will continue to be culturally appropriate for the populations served. All services described should be consistent with those listed in Form 5A. In addition, address any changes in arrangements for services (e.g., directly, via contract, referral).
   (c) Provider staffing (e.g., additions, deletions, staffing agreements).
   (d) Amendments to or termination of existing contractual or referral agreements.
   (e) New contractual or referral agreements (e.g., hospitals, specialty care, after-hours coverage).

3. Discuss the trend in the number of patients served based on the most recent data available compared to the baseline number of patients presented in the organization's most recent designation application. Identify the contributing or restricting factors that have affected any significant increase/decrease in patients served.

4. Describe any significant changes or developments in the ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s). Information provided should be consistent with the Health Care and Business Plans. Specifically address any significant changes in the following areas related to the QI/QA and risk management plan(s):
   (a) How often have QI/QA assessments been conducted (assessments related to medical malpractice risk management, service utilization review, patient satisfaction, quality of care, etc.)?

(b) How have the findings of these QI/QA assessments been used to improve organizational performance and what formal institutional mechanisms/processes are in place to ensure this occurs? Additionally, please discuss:
   i. The organization's Incident Reporting System or efforts to implement such a system.
   ii. How the risk management trends/information gathered is considered when the organization is implementing quality improvement initiatives.

4. Discuss any proposed changes for the upcoming annual recertification period in service delivery locations, services, provider types, and/or hours of operation based on the organization's on-going strategic planning. **NOTE**: HRSA recommendations for annual recertification do not include approval of any potential changes in the future. FQHC Look-Alikes must submit a change in scope application for any proposed changes, and must receive HRSA's approval prior to implementing the change in order for it to be included in the scope of project.

Criterion 3: Evaluative Measures

1. Describe progress made to date on the stated goals of the Health Care Plan (based on the Health Care Plan submitted in the most recent renewal of designation or initial designation application, as applicable). Do not repeat information found in the attached Health Care Plan, but rather reference the attachment and discuss any significant changes in the factors (i.e., contributing or restricting) affecting progress (positive or negative) on the performance measures, and any significant changes in the actions taken in response. Specifically, discuss the following:
   (a) Any significant changes in the contributing or restricting factors affecting progress on Health Care Plan goals, in terms of the trends presented (including those for all performance measures) in the plan and as compared to the most recently approved initial/renewal of designation application, as applicable.
   (b) Any major changes to the key strategies/planned responses to the factors identified and/or changes in the key factors noted above.
   (c) If applicable, any new goals and/or corresponding performance measures that have been added to the Health Care Plan during the recertification period (e.g., goals that were not included in the Health Care Plan submitted in the most recent initial/renewal of designation application).

2. Describe progress made to date on the stated goals of the Business Plan (based on the Business Plan submitted in the most recent renewal of designation or initial designation application, as applicable). Do not repeat information found in the attached Business Plan, but rather reference the attachment and discuss any significant changes in the factors (i.e., contributing or restricting) affecting progress (positive or negative) on the performance measures, and any significant changes in the actions taken in response. Specifically, discuss the following:
   (a) Any significant changes in the contributing or restricting factors affecting progress on Business Plan goals in terms of the trends presented (including those

for all performance measures) in the plan and as compared to the organization's most recently approved initial/renewal of designation application, as applicable.

(b) Any significant changes to the key strategies/planned responses to the factors identified and/or changes in the key factors noted above.

(c) If applicable, any new and/or corresponding performance measures that have been added to the Business Plan during the recertification period (e.g., goals that were not included in the Business Plan submitted in the most recent initial/renewal of designation application).

NOTE: Organizations are not required to attach their original Health Care and Business Plans (that were included in their most recent initial/renewal of designation application) in the annual recertification application. Instead, organizations should complete a progress update of their Health Care and Business Plans per the instructions and sample outlined in Appendix E, "Guidelines for Developing the Health Care and Business Plans," which includes all performance measures. The Health Care and Business Plan tables should not exceed 10 pages total in length.

Organizations that have not submitted a Health Care and Business Plan are encouraged to submit these plans with the annual recertification application. Instructions for initial and renewal of designation application guidelines are in Appendix E, "Guidelines for Developing the Health Care and Business Plans." Organizations may contact BPHC at 301-594-4300 or OPPDGeneral@hrsa.gov for additional guidance.

Criterion 4: Impact

1. Describe any significant changes and/or relevant updates to formal and informal partnerships listed in the most recently approved initial/renewal of designation application. Include a discussion of any significant changes to contracts, MOA/MOUs (e.g., social services, job training, WIC, coalitions, community groups, etc.), and arrangements with organizations that provide services or support to special populations (e.g., outreach, health education, and homeless shelters) listed in the most recently approved initial/renewal of designation application. If there are no significant changes, please indicate this in the response.

   NOTE: Organizations must submit signed and dated copies of any new contracts, MOAs, and MOUs, in Attachment 7.

Criterion 5: Resources and Capabilities

1. Discuss any significant changes to the organizational structure of the FQHC Look-Alike, including any new or significantly revised affiliation agreements/arrangements (as referenced in Form 8) that affect the organization's scope of project. In the case of new or significant changes to affiliation arrangements, describe how these arrangements continue to be in accordance with section 330 program requirements[20]

[20] As stated in PIN 1997-27, "Affiliation Agreements of Community and Migrant Health Centers," and/or PIN 1998-24, "Amendment to PIN 1997-27, "Regarding Affiliation Agreements of Community and Migrant Health Centers."

and are appropriate for the operational and oversight needs of the project. Organizations that serve the general community and/or MSAWs should reference Form 8 throughout the response, as applicable. Any "no" responses to Form 8 should be clearly discussed in this section as well.

2. Discuss any key management staff changes or vacancies over the previous 12-month period and describe plans for filling any vacancies (key management positions are: CEO, CFO, CMO, CIO, and COO, as applicable). Specify how long the key management position(s) has been vacant and if an interim person has been assigned to the position(s). Include a position description for any newly developed positions or any amended position descriptions and a biographical sketch or resume for any newly hired key management staff. The position description should include the roles, responsibilities, and qualifications for the position.

3. Discuss any significant changes to the staffing plan, including any contributing or restricting factors encountered during the previous 12-month period, for recruiting and retaining heath care providers as appropriate for achieving the staffing plan.

4. Discuss any significant changes to the organization's financial accountability, management, and control systems, and any related effect on the organization's financial status. Discuss actions taken to address adverse financial trend(s) in such areas as expenses, revenue, operating deficit, debt burden, or cash flow. If applicable, discuss any findings reported in the most recent financial audit.

5. Discuss any changes in the management information system (e.g., acquisition of new software) and how it impacts the organization's operations.

6. Discuss any new developments (since the last FQHC Look-Alike application) that have occurred related to the status of emergency planning and the organization's progress in developing and/or implementing an emergency preparedness and management plan including participation in any drills or exercises. Discuss participation or attempts to participate with State and local emergency planners.

Criterion 6: Governance

1. Describe any significant changes to the governing board and reasons for such changes, in terms of size, expertise, representation of the service area and target populations[21] served, meeting schedules, etc. Reference Form 6A in your response.[22]

Organizations are encouraged to review the following HRSA web site http://bphc.hrsa.gov/about/requirements.htm for additional information on program requirements.

[21] Organizations that currently serve the general community (CHC) and special populations (HCH, PHPC and/or MHC) should have consumer representation that is reasonably reflective of the populations targeted and served. At minimum, there should be at least one consumer from each of the special population groups for which the organization receives section 330 funding.

[22] Note: Organizations that have an approved waiver of the 51% consumer majority composition requirements are reminded that when completing Form 6A they must list the FQHC Look-Alike's board members on the form and

If the governing board has revised the bylaws during the project period, please discuss the type and purpose of these revisions and provide a signed and dated copy of the amended bylaws.

2. Discuss any significant changes and/or challenges encountered by the governing board and the steps taken to resolve issues in the following areas:
   (a) Exercising required oversight responsibilities and authorities (e.g., selecting and dismissing the CEO/Executive Director, establishing hours of operation, approving annual budget).
   (b) Training new and existing governing board members.
   (c) Evaluating the governing board performance (e.g., discuss any processes that have been developed for addressing board needs/challenges, training needs, communication issues, meeting documentation).
   (d) Using performance trend data (that is consistent with the Health Care and Business Plans and other sources) to inform strategic planning, support ongoing review of the mission and bylaws, evaluate patient satisfaction, review monthly financial and clinical performance, update sliding fee scales, etc.

3. Organizations that are designated to serve a special population authorized under section 330 of the PHS Act and have an approved waiver for the 51% consumer/patient majority requirement must provide an update on the status of the alternative mechanism(s) in place and discuss how the mechanism(s) continues to meet the intent of the statute by ensuring consumer representation. **Note**: An approved waiver does not relieve the FQHC Look-Alike's governing board from fulfilling all other statutory board responsibilities and requirements.

6. Change in Scope Application

Organizations that request to change its scope of project must submit all required information as identified in Section III.3., Application Contents and Format, Column "CS." The specific responses to the program narrative are identified below.

Based on applicable section 330 program regulations, 42 C.F.R. Part 51c.107(c), prior approval is required for significant changes in the program plan including scope of project. The following five types of changes are considered significant and, therefore, require prior approval from HRSA:

(a) Adding a service site not included on Form 4: Service Sites, of the FQHC Look-Alike's most recent FQHC Look-Alike application (initial/recertification/renewal) or approved change in scope request.
(b) Adding a service not included on Form 3: Services Provided, of the FQHC Look-Alike's most recent FQHC Look-Alike application (initial/recertification/renewal) or approved change in scope request.

NOT the members of their advisory council(s) if they have one. Public centers with co-applicant agreements should list the co-applicant board members in Form 6A.

(c) Relocating a service site that was included on Form 4: Service Sites, of the FQHC Look-Alike's most recent FQHC Look-Alike application (initial/recertification/renewal) or approved change in scope request.
(d) Deleting a service site that was included on Form 4: Service Sites, of the FQHC Look-Alike's most recent FQHC Look-Alike application (initial/recertification/renewal) or approved change in scope request.
(e) Deleting a service that was included on Form 3: Services Provided, of the FQHC Look-Alike's most recent FQHC Look-Alike application (initial/recertification/renewal) or approved change in scope request.

Organizations should include in their change in scope request a detailed discussion of any potential impact on the services provided, number of patients served, and number and type of providers. Any unique circumstances that are expected to impact the ability of the organization to meet the expectations for change in scope requests must be fully explained and documented. All requests to change the scope of project must provide evidence of the governing board's approval of the change (i.e., ratified meeting minutes). If the change in scope of project includes additional site(s) that have a different service area and/or target population than those already being served, governing board representation must be modified to represent patients of the added site(s).

The change in scope request must clearly indicate the type of change and demonstrate that the change will be implemented within 120 days of CMS' approval of the request. FQHC Look-Alikes should carefully consider their ability to accomplish the requested change within this anticipated timeframe prior to submitting a request. If an FQHC Look-Alike does not or is unable to implement the requested change in scope within 120 days of approval, the organization must immediately notify the Project Officer in writing with an appropriate justification for the unanticipated delay and a detailed plan for completing the requested scope change. HRSA will consider, on a case-by-case basis, exceptions to the 120 implementation requirement only if the FQHC Look-Alike provides sufficient and compelling justification of the unique and unavoidable circumstances that will prevent the organization from meeting this expectation. The effective date of an approved change in scope will be no earlier than the date of receipt of a complete request for prior approval, and will extend to the end of the FQHC Look-Alike's current designation period. The approved site/service should be included the FQHC Look-Alike's subsequent annual recertification or renewal of designation application.

Requests to add/delete a site(s) must include a narrative description of need in the area served by each site, demographics of the target population, services provided at the site, professional staffing, and a description of the impact of adding or decreasing a site while ensuring the financial viability of the health center. Requests to add/delete a service(s) must include a narrative description of the services and the impact of adding or reducing service(s) while ensuring the financial viability of the health center.

Organizations should coordinate and collaborate with section 330 grantees, other FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or contiguous service areas serving underserved populations to meet the unmet health care needs in the service area. Section 330 of the PHS Act specifically requires that organizations have made "and will

continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center."[23] The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, all organizations. (Refer to PIN 2007-09, "Service Area Overlap: Policy and Process," dated March 12, 2007.)

Refer to PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes," for: (1) special instructions for adding/deleting a site and/or service, relocating a site; (2) special considerations that HRSA evaluates during the change in scope review (i.e., financial impact of the change on the organization and the impact of the change on neighboring health centers/service area overlap); and (3) specific information on how changes to the scope of project affect Medicare and Medicaid FQHC reimbursement and the 340B Federal Drug Pricing Program benefits. Questions regarding the change in scope process, types of changes that require prior approval from HRSA, and any special considerations used during evaluation should be addressed prior to submitting a change in scope application.

IV. APPLICATION REVIEW PROCESS

1. Roles of HRSA and CMS

HRSA and CMS collaboratively administer and monitor the FQHC Look-Alike Program. HRSA is responsible for reviewing all applications and ensuring that organizations are eligible and compliant with all program requirements. CMS has final authority to designate and recertify FQHC Look-Alikes and approve change in scope requests. (Refer to Appendix F for a flow chart of the review process for initial designation and change in scope of project applications.) The roles and responsibilities of each Agency are outlined below.

(a) HRSA Review

Applications submitted to HRSA are reviewed for eligibility, completeness, and compliance based on the applicable requirements, statutes, and policies. Applications determined to be eligible and compliant with all program requirements are recommended to CMS for FQHC Look-Alike designation. Organizations that are determined to be ineligible will receive official notification detailing why the application is ineligible and guidance on how to improve the application.

Applications that are eligible for designation but are incomplete or non-compliant with program requirements will be provided technical assistance (e.g., written notification, conference calls) to remedy the identified issues in order for HRSA to recommend designation. Once all the required information is submitted to HRSA and the organization is determined to be in compliance with all program requirements, HRSA will submit a recommendation for approval to CMS. Organizations must be compliant with all requirements before HRSA can submit a recommendation for FQHC Look-Alike designation to CMS.

[23] Section 330(k)(3)(B) of the PHS Act.

(b) CMS Review

CMS is authorized to designate organizations as FQHC Look-Alikes based on a recommendation from HRSA. HRSA forwards to the CMS Central Office (CO) recommendations for approval regarding initial designation, continued designation (i.e., recertification), and change in scope requests; the CO then forwards a memorandum to the appropriate CMS Regional Office (RO); the RO forwards the request to the applicable State Medicaid Agency/Office for review and comment. If no comments are provided, the recommendation will be approved and HRSA will notify the organization of the approval and the effective date.

In some cases, a State may request an extension to investigate any issues raised during the initial review and comment period. If the issues are not satisfactorily resolved within the extension period, the CMS CO will notify HRSA that the recommendation is not accepted. HRSA then will notify the organization of the disapproval; the organization may continue to work with the State to resolve any outstanding issues and resubmit an application when the issues have been resolved.

2. Review Time Frames by Application Type

The following chart identifies the minimum amount of days required for HRSA to review each type of FQHC Look-Alike application. HRSA's intent is to have adequate time to comprehensively review each application type and provide substantive feedback to the organization if needed. The time frames may vary due to any extenuating issues raised during the review of an application.

NOTE: Due to the varying complexity of change in scope requests, in some cases it may be necessary to extend the HRSA review period if additional analysis, such as an on-site consultation, is warranted. In those cases, HRSA will notify the organization within the initial review period of the potential delays in processing the request. Similarly, on a case-by-case basis, HRSA will notify the organization regarding its projected time frame for reviewing any requested follow-up information based on the nature and complexity of the issue(s). This is illustrated in the second row of the table as to be determined (TBD).

Steps in Process	**ID**	**RD**	**AR**	**CS**
HRSA's initial review of the application per the date HRSA received it.	120	90	45	60
HRSA's review of any requested follow-up information (to be determined based on the issue)	TBD	TBD	TBD	TBD
CMS review and approval process	30	30	30	30

3. Process for Resolving Non-Compliant Renewal of Designation and Annual Recertification Applications

If issues of compliance are raised during the review of the renewal of designation or annual recertification application, HRSA will provide an opportunity for the organization to resolve the issues. HRSA will contact the organization for their response to the issues in order to assure continued compliance with program requirements. Dependent upon the significance of the issue, HRSA will instruct the organization to submit a governing board-approved, time framed plan

detailing how it plans to come into compliance with the requirements. HRSA will recommend for de-designation to CMS those organizations that fail to develop a plan within the established time frame.

Appendix A: Acronyms

APM – Alternative Payment Methodology
AR – Annual Recertification
BBA – Balanced Budget Act
BIPA – Benefits Improvement and Protection Act
BHPR – Bureau of Health Professions
BPHC – Bureau of Primary Health Care
CCN – CMS Certification Number
CEO – Chief Executive Officer
CFO – Chief Financial Officer
C.F.R. – Code of Federal Regulations
CIO – Chief Information Officer
CMO – Chief Medical Officer
CMS – Centers for Medicare and Medicaid Services
CO – Central Office of CMS
COO – Chief Operating Officer
CS (or CIS) – Change in Scope
DTP/DTaP - Diphtheria, Tetanus, and Pertussis
FQHC – Federally Qualified Health Center
FPG – Federal Poverty Guidelines
FTCA – Federal Tort Claims Act
FTE – Full-Time Equivalent
FY – Fiscal Year
GAAP – Generally Accepted Accounting Principles
HHS – Health and Human Services
Hib - Haemophilus Influenzae Type B
HPSA – Health Professional Shortage Area
HRSA – Health Resources and Services Administration
ID – Initial Designation
IPV – Inactive Polio Vaccine
IRS – Internal Revenue Service
LOI – Letter of Interest
MCE – Managed Care Entities
MEI – Medicare Economic Index
MMR - Measles, Mumps and Rubella
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MSAW – Migratory and Seasonal Agricultural Workers
MUA – Medically Underserved Area
MUP – Medically Underserved Population
NAP – New Access Point
NHSC – National Health Service Corps
OBRA – Omnibus Budget Reconciliation Act
OMB – Office of Management and Budget
OPPD – Office of Policy and Program Development

PAL – Program Assistance Letter
PCA – Primary Care Association
PCO – Primary Care Office
PHS – Public Health Service
PIN – Policy Information Notice
PPS – Prospective Payment System
QI/QA – Quality Improvement/Quality Assurance
RD – Renewal of Designation
RO – Regional Office of CMS
SAO – Service Area Overlap
SCHIP – State Children's Health Insurance Plan
SSA – Social Security Act
TBD – To Be Determined
UDS – Uniform Data System
USC – United States Code

Appendix B: Glossary

340B Federal Drug Pricing Program: The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the PHS Act. Section 340B limits the cost of covered outpatient drugs to certain Federal grantees, FQHC Look-Alikes and qualified Disproportionate Share Hospitals. Significant savings on pharmaceuticals may be seen by those entities that participate in this program. The terms "PHS Pricing," "340B Pricing," and "602 Pricing" reference the same program and the same discount. The terms "ceiling price" and "discount price" are considered the same. For additional information about the 340B Federal Drug Pricing Program, please contact HRSA's Office of Pharmacy Affairs at http://www.hrsa.gov/opa/ or 1-800-628-6297.

Active Patient: A patient is an individual who has at least one visit during the year within the organization's approved scope of project. A patient does not include an individual who only has visits such as outreach, community education services, and other types of community-based services not documented on an individual basis. Also, a person who only receives services from large-scale efforts such as mass immunization programs, screening programs, and health fairs is not a patient. A person whose only contact with the FQHC Look-Alike is to receive Women, Infants, and Children (WIC) counseling and vouchers is not a patient and the contact does not generate a visit.

Actual accrued income: The amount received by the organization for this type of payor in the most recent 12-month period for which the organization has data.

Additional Services: Services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the health center. Additional health services are appropriate when "necessary for the adequate support of . . . primary health services" (section 330(b)(2) of the PHS Act).

Census Tracts: Small, relatively permanent statistical subdivisions of a county designed to be relatively homogeneous units with respect to population characteristics, economic status, and living conditions, census tracts average about 4,000 inhabitants. Tracts are delineated by a local committee of census data users for the purpose of presenting data. Census tract boundaries normally follow visible features, but may follow governmental unit boundaries and other non-visible features in some instances; they always nest within counties. Information to determine the census tracts with a given service area is available online at http://www.census.gov/geo/www/tractez.html.

Cultural Competency: HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care published by the U.S. Department of Health and Human Services. This document is available online at http://www.omhrc.gov/CLAS.

Wherever appropriate, identify programs, training and technical assistance implemented to improve health communications to foster healing relationships across culturally diverse populations.

Wherever appropriate, describe the program's or organization's strategic plan, policies, and initiatives that demonstrate a commitment to providing culturally and linguistically competent health care and developing culturally and linguistically competent health care providers, faculty, staff, and program participants. This includes participation in and support of, programs that focus on cross-cultural health communication approaches as strategies to educate health care providers serving diverse patients, families, and communities.

Whenever appropriate, identify programs that work to: (1) improve medication compliance of patients, (2) improve patient understanding regarding health conditions, and (3) improve the ability of the patient to manage their condition.

Wherever appropriate, describe a plan to recruit and retain key staff with demonstrated experience serving the specific target population and familiarity with the culture and language of the particular communities served:

- Wherever appropriate, summarize specific training, and/or learning experiences to foster knowledge and appreciation of how culture and language influences health literacy, patient safety, and access to high quality, effective, and predictably safe healthcare services.

- Wherever appropriate, provide a plan for using training to increase self-awareness of multicultural and health literacy issues and engage individuals, families, and communities from diverse social, cultural, and language backgrounds in self-managing their health care.

- Wherever appropriate, describe the program or organization's strategic plan, policies, and initiatives that demonstrate a commitment to serving the specific target population and familiarity with the culture and literacy level of the particular target group.

- Wherever appropriate, describe the program's or organization's past performance in recruiting and retaining health care providers, faculty, staff, and students with demonstrated experience serving the specific target population and familiarity with the culture of the particular target group.

- Wherever appropriate, describe a plan to recruit and retain staff, health care providers, faculty, and students with demonstrated experience serving the specific target population and familiarity with the culture and literacy level of the particular target group.

- Wherever appropriate, describe the organization's strategic plan, policies, and initiatives that demonstrate a commitment to developing culturally and linguistically competent health care providers, faculty, and students.

- Wherever appropriate, present a summary of specific training, and /or learning experiences to develop knowledge and appreciation of how culture and language influences health literacy improvement and the delivery of high quality, effective, and predictably safe healthcare services.

- Wherever appropriate, describe how training and/or learning experiences will increase staff awareness in serving the specific target population and familiarity with the culture and language of the particular target group.

Additional resource information can be found on the HRSA cultural competence web page, located at http://www.hrsa.gov/culturalcompetence.

Enabling Services: Per section 330(b)(1)(A)(iv) of the PHS Act, enabling services are non-clinical services that enable individuals to access health care services and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction (e.g., educational materials, nicotine gum/patches), and outreach.

Federal Tort Claims Act (FTCA): The Federally Supported Health Centers Assistance Act of 1992 and 1995 (the Act) granted medical malpractice liability protection through the FTCA to health centers receiving grant funds under section 330 of the PHS Act. Under the Act, section 330 grantees, their employees, and eligible contractors are considered Federal employees immune from suit with the Federal government acting as their primary insurer. FQHC Look-Alikes are not eligible for FTCA coverage.

Federally Qualified Health Center (FQHC): A category of facilities under Medicare and Medicaid as identified in the OBRA of 1989, 1990, and 1993. The three types of FQHCs are: organizations receiving grants under section 330 of the PHS Act, certain tribal organizations, and FQHC Look-Alikes (authorized under section 1861(aa)(4) and section 1905(1)(2)(B) of the SSA). Requirements for tribal organizations designated as FQHCs differ from organizations that receive grants under section 330 of the PHS Act and FQHC Look-Alikes.

Full-Time Equivalent (FTE) Employee: A FTE of 1.0 means that the person worked full-time for one year. Each agency defines the number of hours for "full-time" work. For example, if a physician is hired full-time and works 36 hours per week as is specified in her contract, she is a 1.0 FTE. The FTE is based on employment contracts for clinicians and exempt employees; FTE is calculated based on paid hours for nonexempt employees. FTEs are adjusted for part-time work or for part-year employment. In an organization that has a 40 hour work week (2080 hours/year), a person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." In some organizations different positions have different time expectations. Positions with different time expectations, especially clinicians, should be calculated on whatever they have as a base for that position. Thus, if physicians work 36 hours per week, this would be considered 1.0 FTE, and an 18 hour per week physician would be considered as 0.5 FTE, regardless of whether other employees work 40 hours weeks. FTE is also based on the number of months the employee

works. An employee who works full time for four months out of the year would be reported as "0.33 FTE" (4 months/12 months).

Staff may provide services on behalf of the FQHC Look-Alike under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, NHSC assignment, under contract, or donated time. Individuals who are paid by the FQHC Look-Alike on a fee-for-service basis only and do not have specific assigned hours, are not counted in the calculation of FTEs since there is no basis for determining their hours.

Health Professional Shortage Areas (HPSAs): Federally-designated areas that have shortages of primary medical care, dental or mental health providers and may be urban or rural areas, population groups or medical or other public facilities. A list of HPSA designations is available on HRSA's web site at http://bhpr.hrsa.gov/shortage/.

Homeless: Per section 330(h)(5)(A) of the PHS Act, the term "homeless individual" means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night that is a supervised public or private facility that provides temporary accommodations and an individual who is a resident in transitional housing.

Medically Underserved Area (MUA)/Medically Underserved Population (MUP): Grantees under section 330 of the PHS Act and FQHC Look-Alikes are required under the statute to serve, in whole or in part, areas or populations designated by the Secretary of Health and Human Services as medically underserved. (**NOTE**: This is not required for organizations only serving MSAW, homeless, and/or public housing populations.) Guidelines for use in applying the established criteria for designation of MUAs and MUPs are based on the Index of Medical Underservice (IMU), published in the Federal Register on October 15, 1976. Guidelines for use in submitting requests for exceptional MUP designations are based on the provisions of Public Law 99-280 enacted in 1986. The three methods for designation of MUAs and MUPs can be found at http://bhpr.hrsa.gov/shortage/muaguide.htm.

Migratory and Seasonal Agricultural Workers: Per section 330(g)(3)(A) of the PHS Act, the term "migratory agricultural worker" means an individual whose principal employment is in agriculture, who has so been employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode. Per section 330(g)(3)(B) of the PHS Act, the term "seasonal agricultural worker" means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

For both categories of workers, agriculture is defined as farming of the land in all its branches, including cultivation, tillage, growing, harvesting, preparation, and *on-site* processing for market or storage. NOTE: Persons employed in *aqua*culture, lumbering, poultry processing, cattle ranching, tourism and all other non-farm-related seasonal work are not included.

New Access Point: A new access point is a new delivery site for the provision of comprehensive primary and preventive health care services. Every competitive new access point

demonstrates compliance with the applicable requirements of section 330 of the PHS Act, the 42 C.F.R. 51c, and HRSA policies. To be competitive, new access point applications must:

(a) demonstrate that all persons will have ready access to the full range of required primary, preventive, enabling (see definition above) and supplemental health services, including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay;
(b) demonstrate compliance at the time of application (or a plan for compliance within 120-days of a grant award) with the requirements of section 330, and its implementing regulations;
(c) demonstrate how section 330 funds will expand services and increase the number of people served through the establishment of a new service delivery site(s) and/or at an existing site(s) not currently within a HRSA funded scope of project;
(d) demonstrate that the site(s) will be operational and services will be initiated within 120 days of a grant award; and
(e) demonstrate how section 330 funds will augment already available funds and in-kind resources to expand existing primary health care service capacity to currently underserved populations.

Required Primary Care Services: Section 330(b)(1)(A) of the PHS Act defines the term "required primary health services" as:

(i) basic health services which, for the purposes of this section, shall consist of -
  (I) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
  (II) diagnostic laboratory and radiologic services;
  (III) preventive health services, including—
    (aa) prenatal and perinatal services;
    (bb) appropriate cancer screening;
    (cc) well-child services;
    (dd) immunizations against vaccine-preventable diseases;
    (ee) screenings for elevated blood lead levels, communicable diseases, and cholesterol;
    (ff) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
    (gg) voluntary family planning services; and
    (hh) preventive dental services;
  (IV) emergency medical services; and
  (V) pharmaceutical services as may be appropriate for particular centers;
(ii) referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance abuse and mental health services);
(iii) patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services;
(iv) services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a

center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and

(v) education of patients and the general population served by the health center regarding the availability and proper use of health services.

Risk Management: The process of making and carrying out decisions that will assist in preventing adverse consequences and minimizing adverse effects of accidental losses upon an organization. Also, a systematic and scientific approach in the empirical order to identify, evaluate, reduce or eliminate the possibility of an unfavorable deviation from expectation and, thus, to prevent the loss of financial assets resulting from injury to patients, visitors, employees, independent medical staff, or from damage, theft, or loss of property belonging to the health care entity or persons mentioned. Risk management also encompasses the evaluation and monitoring of clinical practice to recognize and prevent patient injury.

School-Based Health Center: A health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services.

Scope of Project: Defines the activities that the total approved grant-related project budget or FQHC Look-Alike designation supports. Specifically, the scope of project defines the service sites, services, providers, service area(s) and target population for which section 330 grant funds and FQHC Look-Alike designation benefits may be used. For more information please see PIN 2008-01.

Section 1115 Waiver Demonstration Programs: Section 1115 of the SSA provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow States to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some States expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

There are two types of Medicaid authority that may be requested under Section 1115:

- Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs, and
- Section 1115(a)(2) – allows the Secretary to provide Federal financial participation for costs that otherwise can not be matched under Section 1903.

Projects are generally approved to operate for a five-year period and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they can not be expected to cost the Federal government more than it would cost without the waiver.

Service Area: The concept of a service or "catchment" area has been part of the section 330 program since its beginning. In general, the service area is the area in which the majority of the

organization's patients reside. The section 330 authorizing statute requires that each grantee/FQHC Look-Alike periodically review its catchment area to:

> (i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;
>
> (ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and
>
> (iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation. (Section 330(k)(3)(J) of the PHS Act.)

The service area should, to the extent practicable, be identifiable by census tracts. Describing service areas by census tracts is necessary to enable analysis of service area demographics. Service areas may also be described by other political or geographic subdivisions (e.g., county, township, zip codes as appropriate). The service area must be designated in full or in part as a MUA or contain a designated MUP. While organizations may serve patients from outside their service area, they must provide access to services for all residents of the service area[24] regardless of ability to pay. Please see PIN 2007-09, "Service Area Overlap: Policy and Process," for more information.

Service Site[25]**:** Any location where a section 330-funded health center or FQHC Look-Alike, either directly or through a subrecipient, provides primary health care services to a defined service area or target population. Service sites are defined as locations where all of the following conditions are met (for more information, please see PIN 2008-01):

- health center visits are generated by documenting in the patients' records face-to-face contacts between patients and providers;
- providers exercise independent judgment in the provision of services to the patient;
- services are provided directly by or on behalf of the health center, whose governing board retains control and authority over the provision of the services at the location; and
- services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month). However, there is no minimum number of hours per week that services must be available at an individual site.

Sliding Discount: Discounts (also referred to as a "sliding fee scale" or "schedule of discounts") must be provided to patients at or below 200% of the FPG (available at

[24] Section 330 grantees funded and FQHC Look-Alikes designated to serve exclusively a section 330 authorized special population (i.e., section 330 (g), (h), and/or (i)) are not subject to the requirement to serve all residents of the service area. (Section 330(a)(2) of the PHS Act)

[25] Note the statutory requirement in section 330(k)(3) of the PHS Act that "primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity." In addition, note the regulatory requirement in 42 C.F.R. Part 51c.303(m) that health centers "must be operated in a manner calculated ... to maximize acceptability and effective utilization of services."

http://aspe.hhs.gov/poverty/) based on their ability to pay. Those at or below 100% of the poverty guidelines must receive a 100% (full) discount (they may pay a nominal fee if consistent with program goals and as long as such as a fee does not result in the denial of health care services due to an individual's inability to pay). Health centers must establish their own schedule of discounts based on income and family size as it relates to the FPG with the discount applied to the charge for services "sliding" downwards from 0% (no discount-full charge for those individuals with incomes over 200% of the FPG) to 100% (full discount). The number of distinct categories of discounts is chosen by the health center.

Specialty Service: Specialty services are considered to be within the broad category of "additional" health services, defined in section 330 as services that are not included as required primary health care services and that are: (1) necessary for the adequate support of primary health services, and (2) appropriate to meet the health needs of the population served by the health center" (section 330(a)(1)(B) and section 330(b)(2) of the PHS Act). Please refer to PIN 2009-02, "Specialty Services and Health Centers' Scope of Project," for additional information on specialty services.

Target Population: The medically underserved population to be served by the health center. It is usually a subset of the entire service area population, but in some cases, may include all residents of the service area.

Section 330(e) grantees and FQHC Look-Alikes are required to serve all residents of the center's service area, regardless of the individual's ability to pay, including MSAWs, homeless populations and residents of public housing. Although they may also extend services to those residing outside the service area, HRSA recognizes that health centers must operate in a manner consistent with sound business practices.

Grantees funded and FQHC Look-Alikes designated to serve exclusively a section 330 authorized special population(s) (i.e., section 330(g), (h), and/or (i)) must support care for the specific population(s) and, as such, are not subject to the requirement to serve all residents of the service area). However, all section 330 grantees and FQHC Look-Alikes should address the acute care needs of all who present for service, regardless of residence. In the case of section 330 grantees and FQHC Look-Alikes, individuals who are not members of the special population group(s) served by the health center may be seen initially and then referred to more appropriate settings for their non-acute health care needs. Those grantees and FQHC Look-Alikes serving a special population may not have more than 25% of patients from the general population. Please refer to PIN 2009-05, "Policy for Special Population-Only Grantees Requesting a Change in Scope to Add a New Target Population," for additional information.

Uniform Data System (UDS): The UDS is a reporting requirement for section 330 funded health centers. It is the core set of information appropriate for monitoring and evaluating health center performance and reporting on trends. UDS collects basic demographic information on populations served, such as race/ethnicity and insurance status of patients. The data helps to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve access to primary health care for vulnerable populations. UDS data is also compared with national data to look at differences between the

U.S. population at large and those individuals and families who rely on the health care safety net for primary care.

Visit: Visits are a documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented.

Appendix C: Resources

Organizations may find the following websites and resources helpful when preparing the application:

Applicable Laws, Regulations, and HRSA Policies

- Office of Management and Budget Circular A-133
  http://www.whitehouse.gov/omb/circulars/a133/a133.html

- Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended
  http://bphc.hrsa.gov/about/legislation/section330.htm

- Code of Federal Regulations, Title 42, Part 51c, Grants for Community Health Services
  http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=f141dbc68d6d3a084d2177ebbe01e543;rgn=div5;view=text;node=42%3A1.0.1.4.25;idno=42;cc=ecfr

- Code of Federal Regulations, Title 42, Part 56, Grants for Migrant Health Services and Centers http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=ee293ee6017d803088ad94f24d79eb07;rgn=div5;view=text;node=42%3A1.0.1.4.39;idno=42;cc=ecfr

- Code of Federal Regulations, Title 45, Part 75, Grant Award Requirements,
  http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=9de47029ddc8d5924737e389e539f183&rgn=div5&view=text&node=45:1.0.1.1.35&idno=45

- PAL 2006-01, "Dual Status Health Centers (that are both FQHC Look-Alikes and Section 330 Grantees" (signed April 24, 2006) http://bphc.hrsa.gov/policy/pal0601.htm

- PAL 2008-07, "Federally Qualified Health Center Look-Alike Site Visits" (signed September 9, 2008) http://bphc.hrsa.gov/policy/pal0807.htm.

- PAL 2009-04, "Updating National Health Service Corps Vacancy Lists: A Critical Step to Address Health Centers' Workforce Needs" (signed March 23, 2009) http://bphc.hrsa.gov/policy/pal0904/.

- PIN 1998-24, "Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community and Migrant Health Centers" (signed August 17, 1998) http://bphc.hrsa.gov/policy/pin9824.htm.

- PIN 1997-27, "Affiliation Agreements of Community and Migrant Health Centers" (signed July 22, 1997) http://bphc.hrsa.gov/policy/pin9727.htm.

- PIN 1999-09, "Implementation of the Balanced Budget Act Amendment of the Definition of

Federally Qualified Health Center Look-Alike Entities for Public Entities" (signed April 20, 1999) http://bphc.hrsa.gov/policy/pin9909.htm.

- PIN 1999-10, "Implementation of the Balanced Budget Act Amendment of the Definition of Federally Qualified Health Center Look-Alike Entities for Private Nonprofit Entities" (signed April 20, 1999) http://bphc.hrsa.gov/policy/pin9910.htm.

- PIN 2007-09, "Service Area Overlap: Policy and Process" (signed March 12, 2007) http://bphc.hrsa.gov/policy/pin0709.htm.

- PIN 2007-15, "Health Center Emergency Management Program Expectations" (signed August 22, 2007) http://bphc.hrsa.gov/policy/pin0715/.

- PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes" (signed December 31, 2007) http://bphc.hrsa.gov/policy/pin0801/.

- PIN 2009-02, "Specialty Services and Health Centers' Scope of Project" (signed December 18, 2008) http://bphc.hrsa.gov/policy/pin0902/default.htm.

- PIN 2009-03, "Technical Revision to PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes" (signed January 13, 2009) http://bphc.hrsa.gov/policy/pin0903.htm.

- PIN 2009-05, "Policy for Special Populations-Only Grantees Requesting a Change in Scope to Add a New Target Population" (signed March 23, 2009) http://bphc.hrsa.gov/policy/pin0905/.

Related Federal Agencies and Offices

- *HRSA, Bureau of Health Professions* – Information on HPSA, MUA, MUP. http://bhpr.hrsa.gov/shortage/

- *HRSA, Bureau of Clinician Recruitment and Service*– Information on National Health Service Corps. http://nhsc.hrsa.gov/

- *HRSA, Bureau of Primary Health Care* – Information on the Health Center Program. http://bphc.hrsa.gov/about/apply.htm

- *HRSA, Grants: Find, Apply, Manage, Review, and Report* – List of available HRSA funding opportunities. http://www.hrsa.gov/grants/default.htm.

- *HRSA, Office of Pharmacy Affairs & 340B Drug Pricing Program.* http://www.hrsa.gov/opa/

- *Centers for Medicaid and Medicare Services Medicaid Provider Enrollment* – Instructions for obtaining a Medicaid provider number. http://www.cms.hhs.gov/home/medicaid.asp

- *Centers for Medicaid and Medicare Services Medicare Provider Enrollment* – Instructions for obtaining a Medicare provider number. http://www.cms.hhs.gov/home/medicare.asp

Application Development Assistance

- *Federal Audit Clearinghouse Homepage* – Guidelines for preparing an A-133 Audit. http://harvester.census.gov/sac/

- *Governing Board Handbook* – Tool to assist new board members to understand the structure and responsibilities of a governing board. http://www.fachc.org/cd_Governing%20board%20handbook.pdf

- *National Cooperative Agreements Directory* – Various national organizations that provide specialized assistance in: capital development and financing, oral health care, organizations serving special populations, clinical quality improvement, and State and local government. http://bphc.hrsa.gov/technicalassistance/ncadirectory.htm

- *State and Regional Primary Care Associations Directory* – Provides assistance to organizations in developing, strengthening and expanding health centers on a State or regional level. http://bphc.hrsa.gov/technicalassistance/pcadirectory.htm

- *State Primary Care Offices Directory* – Provides assistance to health centers around Medicaid issues, State health policy, MUA/MUP/HPSA, etc. http://granteefind.hrsa.gov/searchbyprogram.aspx?select=U68&index=203

Appendix D: Benefits of FQHC Look-Alike Designation

1. Reimbursement under Medicare and Medicaid

Medicare FQHC Reimbursement Methodology

Medicare reimburses health centers enrolled as FQHCs based on an all-inclusive rate for each visit by a Medicare beneficiary. Medicare fiscal intermediaries set the all-inclusive rate based on each FQHC's estimate of allowable cost to be incurred during the reporting period divided by the number visits expected to be furnished during the reporting period. At the beginning of the FQHC's fiscal year, the Fiscal Intermediary or A/B Medicare Administrative Contractor (MAC) calculates an interim all-inclusive visit rate based on either estimated allowable costs and visits from the FQHC (if it is new to the FQHC Program) or on actual costs and visits from the previous cost reporting period (for existing FQHCs). The FQHC's interim all-inclusive visit rate is reconciled to actual reasonable costs at the end of the cost reporting period.[26]

Congress mandated the use of a national upper payment limit in OBRA of 1990, specifying payment for FQHC services under the authority of sections 1833(a)(3) and 1861(v)(1) of the SSA. There are two FQHC payment limits: one limit applies to entities located in urban areas and one limit applies to entities located in rural areas. These rates are adjusted annually by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care physician's services.[27]

FQHCs that have received a CMS Certification Number (CCN) and participation date from CMS are eligible to be reimbursed by Medicare under the FQHC payment methodology.

Please note that it is the FQHC's responsibility to submit materials necessary to obtain a CCN and participation date (CMS 855A form and supporting documentation) with its CMS fiscal intermediary/MAC; it is also their responsibility to monitor its progress through the review and approval process.[28] Any services provided to Medicare patients prior to the FQHC's participation date will be reimbursed at the standard Medicare rate only.

The CMS 855A form may be accessed on-line at
http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf

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[26] CMS FQHC/Medicare Fact Sheet, pg 3, http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf.

[27] The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies. (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1944)

[28] In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. Eventually, all Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs. Providers may view the list of current MACs for each jurisdiction at http://www.cms.hhs.gov/MedicareContractingReform on the CMS web site. (http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf)

For additional information on Medicare:

- See the Medicare FQHC Fact Sheet at http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf
- Contact the Medicare office at: 1-800-633-4227.
- Visit the CMS website at: http://www.cms.hhs.gov/.

Medicaid FQHC Reimbursement Methodology

State Medicaid Agencies reimburse FQHCs under a prospective payment system (PPS) or an equivalent alternative payment methodology (APM), as specified in section 1902(bb) of the SSA. The payment methodology should be described in the approved State plan.

Prospective Payment System: Under PPS, States pay FQHCs participating prior to fiscal year 2000 the average of the reasonable costs of providing Medicaid-covered services during two base years, adjusted for inflation or a change in the scope of services. The PPS baseline rate was calculated using 100 percent of the reasonable costs incurred during fiscal year 1999 and fiscal year 2000. This calculation should have included all Medicaid covered services payable as FQHC services under 1905(a)(2)(C) of the Act. For FQHCs initially participating in years after fiscal year 2000, the initial PPS rate is based on the rates established during that year for other such centers or clinics in the same or adjacent area with a similar case load (or based on the actual costs determined in accordance with Medicare payment principles). The initial PPS rate is subject to adjustment, as discussed below.

Alternative Payment Methodology: A State may, in reimbursing an FQHC for services furnished to Medicaid beneficiaries, use an APM, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which it is entitled under the Medicaid PPS.

In order to become eligible for FQHC reimbursement from Medicaid, FQHCs must enroll in their State Medicaid as an FQHC provider. Each state has its own Medicaid provider enrollment process. FQHCs are required to work directly with their State Medicaid office. The initial reimbursement payments for newly designated FQHCs is determined based on the rates of surrounding FQHCs, or in the absence of other FQHCs in the area, by cost reporting methods. After the initial year, payment is set by using the MEI factor used for other FQHCs.

Adjustments: In FY 2002 and for each FY thereafter, each FQHC is entitled to a PPS payment amount (on a per visit basis) after its initial year of the PPS amount to which the health center was entitled in the previous FY, increased by the percentage increase in the MEI for primary care services. The "per visit" rate may also be adjusted to take into account any increase (or decrease) in the scope of Medicaid covered services furnished by the FQHC during that FY

NOTE: A change in scope of project for an FQHC is NOT THE SAME as a change in scope of service for increased/decreased Medicaid reimbursement. Some States may require proof of the HRSA's approval of the change in scope of service to process a Medicaid rate change. FQHCs

should refer to their State's Medicaid policies and procedures when requesting payment adjustments due to a change in scope of services.

Supplemental Payment: Section 1902(bb)(5) of the SSA requires States to make supplemental payment to FQHCs that subcontract (directly or indirectly) with Managed Care Entities (MCEs). Under section 1903(m)(2)(A)(ix), the MCE must pay the FQHC no less than it would make if the services were furnished by another provider. The State supplemental payment represents the difference, if any, between the payment received by the FQHC for treating the MCE enrollees and the payment to which the FQHC would be entitled for these visits under the Medicaid PPS provision of BIPA.

Contracted Services: Health centers may be eligible for Medicare and Medicaid FQHC reimbursement for the cost of contracted services that are furnished to patients of the FQHC as part of an FQHC visit; however, they are not eligible to receive reimbursement for referred services not paid for by the health center, or not provided to the individual as a patient of the FQHC.

FQHC Children's Health Insurance Plan (CHIP) Reimbursement Methodology
Under the CHIP Reauthorization Act of 2009, starting on October 1, 2009, all State CHIP plans will be required to pay FQHCs according to Section 1902(bb).

Outstationed Eligibility Workers
State Medicaid Agencies are required to place outstationed eligibility workers at each FQHC participating in the State's Medicaid program. These workers can be state employees, or the FQHC can contract with State Medicaid agencies for FQHC staff to carry out these outstationing activities (such contracts can include reimbursement for the costs of such staff, or can provide for donation of those costs by the clinic). Note that States have the option to propose alternative outreach plans that may not include placing workers at all FQHCs. However, these plans must be approved by CMS. FQHCs who are interested in having workers on-site to assist pregnant women and children in enrolling in Medicaid should contact their State Medicaid Agency. For information about how to determine if CMS has approved an alternative program for your State, please contact your State Medicaid Agency. General information about this requirement program is described in this State Medicaid Director's letter http://www.cms.hhs.gov/smdl/downloads/smd011801b.pdf.

2. 340B Drug Pricing Program
Organizations designated as FQHC Look-Alikes are eligible to purchase prescription and non-prescription medications for their outpatients at a reduced cost through the 340B Drug Pricing Program.

FQHC Look-Alikes may apply for participation in the 340B Drug Pricing Program without operating or owning a pharmacy and can contract with a local pharmacy to meet the needs of their patient base. The FQHC Look-Alike must order and pay for the drugs, which are delivered to the local pharmacy for distribution to patients at discounted prices that comply with the sliding fee scale requirements in section 330 of the PHS Act. It is important that the contract state that the FQHC Look-Alike is billed and receives the invoice, NOT the pharmacy paying for the drugs. For additional information about the 340B Program and enrollment requirements, contact

the HRSA Office of Pharmacy Affairs, Pharmacy Services Support Center at 1-800-628-6297 or http://www.hrsa.gov/opa/.

3. Health Professional Shortage Area Designation and National Health Service Corps Recruitment and Retention Assistance

All FQHC Look-Alikes are eligible to receive recruitment and retention assistance available through the National Health Service Corps (NHSC).

A Health Professional Shortage Area (HPSA) means any of the following which the Secretary of the HHS determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; (3) a public or nonprofit private medical facility; or (4) an entity eligible for automatic HPSA status, including FQHC Look-Alikes.

Benefits of the HPSA Designation: The HPSA status aids health centers in their efforts to recruit and retain health professionals. The HPSA designation confers: (1) basic eligibility to apply to receive NHSC personnel (scholars, loan repayors, or Ready Responders); and (2) eligibility to be a site where a J-1 visa physician can serve [upon recommendation from a State or an interested U.S. government agency such as the Appalachian Regional Commission (ARC), or Department of Health and Human Services (DHHS)].

NHSC Clinical Vacancy List: For successful recruitment of health professionals, it is important to: (1) develop and maintain an accurate list of current clinical vacancies; and (2) make the list widely available to providers seeking positions at health centers or other facilities serving the underserved. An excellent source for accomplishing these goals is the NHSC Opportunities List (List), an on-line list of opportunities in HPSAs. All FQHC Look-Alike vacancies are eligible to be included on the list, which is available at http://nhscjobs.hrsa.gov/. NHSC personnel must serve at a vacancy on the list; with the NHSC giving priority to the placement of its personnel in HPSAs of greatest shortage (see "HPSA Score" below). In addition, physicians on J-1 visas often use the list to identify vacancies in HPSAs where they can serve in return for a waiver of their return home requirement. States participating in the State Loan Repayment Program and available clinicians with no service obligation, who are looking for a job where they can serve the underserved, may also use this list.

Application Requirement: An FQHC Look-Alike's vacancies must be on the list before the health center can receive NHSC personnel. The health center must apply to the NHSC by completing the NHSC Recruitment and Retention Assistance Application (available at ftp://ftp.hrsa.gov/nhsc/communities/siteapplication.pdf. Once an organization files the NHSC Recruitment and Retention Assistance Application and the NHSC approves the application, its vacancy(ies) will be included on the list. Inclusion of an FQHC Look-Alike vacancy on the list does not assure that the health center will receive NHSC providers or physicians on J-1 visas.

Site Profile, Website Links: FQHC Look-A-likes may also complete the Site Profile form. This site-specific information can be linked to its site on the List, allowing interested individuals an

opportunity to learn more about the site. If the site or organization has an existing website, it can provide its Uniform Resource Locator (i.e., URL) for additional information.

HPSA Score: The NHSC is required to give priority to the placement of its providers in HPSAs of greatest need. A HPSA score, which measures HPSA need, has been automatically computed for every designated FQHC. HPSA scores and a discussion about how they were developed are available at the Shortage Designation web site http://bhpr.hrsa.gov/shortage/autoscore.htm. If an FQHC Look-Alike is located in a geographic or population group HPSA, the score for that HPSA can be used instead of the automatic score. Generally, the NHSC Scholarship, Ready Responder, and DHHS J-1 Programs have cut off scores below which FQHCs will not be eligible to participate. For the NHSC Loan Repayment Program, the HPSA score influences the order in which qualified organizations are approved to participate in the program. HPSA scores are not a factor for the "Conrad" State and ARC J-1 Programs. Please contact your State PCO for assistance in improving a HPSA score. The PCO has the background and expertise in the designation process.

For Further Information: For questions about the NHSC Recruitment and Retention Assistance Application, NHSC Opportunities List, or other related matters, please contact the NHSC Recruitment Training and Support Center at 1-800-221-9393. For additional questions about the HPSA designation process, please contact the HRSA, Bureau of Health Professions (BPHr), Office of Shortage Designation at 301-594-0816. Facilities are added to the HPSA database on an on-going basis, and are included in the HPSA Database Web Look-Up found on the BPHr web page http://bhpr.hrsa.gov/shortage.

Appendix E: Guidelines for Developing the Health Care Plan and Business Plan

The Health Care Plan and Business Plan serve as an ongoing monitoring and evaluation tool for FQHC Look-Alikes and HRSA. The Plans should outline time-framed and realistic goals and related performance measures (as referenced below) with baselines that are responsive to the identified primary health care needs of the community served and the strategic needs of the organization overall organization, including multiple sites and/or various activities at multiple sites. If baselines are not yet available, identify when the data will be available. If designated, FQHC Look-Alikes must report on the progress of achieving the goals and baselines during each annual recertification application, as well as develop new goals and baselines for each renewal of designation application.

Performance Measures
Organizations are expected to integrate the health center performance measures within each Need/Focus Area identified below into their Health Care and Business Plans, as appropriate. wThe health center performance measures are assessable on HRSA's Web site at http://bphc.hrsa.gov/about/performancemeasures.htm. Additional information on the Health Care Plan performance measures can be found in the annual Uniform Data System Reporting Manual available at http://bphc.hrsa.gov/uds/. Additional technical assistance related to the Health Care and Business Plan measures is available through HRSA and the State PCA.

- Please note that only applicants that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the applicant does the delivery, are required to include prenatal performance measures, including the required measures: Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients.

- If the applicant is applying for FQHC Look-Alike designation to target special populations (e.g., migrant/seasonal agricultural workers, residents of public housing, homeless persons), they are encouraged to include additional goals and related performance measures that address the unique health care needs of these populations in the Plan(s), as appropriate.

- If the applicant has identified other unique populations, life-cycles, health issues, risk management efforts, etc. in the narrative Need section, they are encouraged to include additional goals and related performance measures in the Plan(s) as appropriate.

- Any additional narrative regarding the Program Specific Information (Health Care and Business Plans) should be included in the Evaluative Measures section of the program narrative, as appropriate.

Applicants are expected to address the Performance Measures provided by HRSA in their Health Care and Business Plans, as applicable. All applicants are expected also include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure of their choice in the Health Care Plan. (Please visit http://bphc.hrsa.gov/about/performancemeasures.htm to view the HRSA performance measures.)

Applicants may also wish to consider utilizing Healthy People 2010 goals and performance measures when developing their Health Care and Business Plans. Healthy People 2010 is a national initiative led by HHS that sets priorities for all HRSA programs. The program consists of 28 focus areas and 467 objectives. Further information on Healthy People 2010 goals may be downloaded at: http://www.healthypeople.gov/document/.

Instructions and Format for Initial/Renewal of Designation Health Care and Business Plans

Applications for initial/renewal of designation are expected to develop goals and baselines that can be achieved in a five-year period, starting January 1 and ending December 31. Use the sample initial/renewal of designation application Health Care and Business Plan formats provided in this appendix. Please refer to Section III.5.Criterion 3 - Evaluative Measures, for the specific elements that must be addressed in the initial/renewal of designation Health Care and Business Plans. The Plans collectively should not exceed 30 pages.

Need Addressed/Focus Area

This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population and/or organization (Diabetes; Cardiovascular; Costs, Productivity; etc.). Applicants are expected to address each required performance measurement area (as described in the table above) as well as any other key needs of their target population or organization as identified in the application narrative.

Project Period Goal(s) with Baseline

Goals relating to the Need/Focus Area should be listed in this section. Applicants should provide goals for the required performance measures listed above as well as other goals, which can be accomplished by the end of the multi-year project period. The goal should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide Baseline data to indicate their status at or prior to the beginning of the project period. Baseline data provides a basis for quantifying the amount of progress/improvement to be accomplished in the project period. If applicants choose to establish a baseline for any of the new Health Care Plan measures, they are encouraged to utilize current data. Applicants are expected to track performance against these goals throughout the entire approved project period and to report interim progress achieved on the goal in subsequent annual recertification applications.

Performance Measure(s)

Applicants must make use of the required performance measures listed above when setting goals in the Project Period Goal(s) with Baseline section (also noted in the sample Plans). Applicants may also include additional performance measures. Additional measures chosen by the applicant should also define the numerator and denominator that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Data Source & Methodology

The source of performance measure data, method of collection and analysis (e.g., electronic health records, disease registries, chart audits/sampling) should be noted by the applicant. Data should be valid and reliable and derived from currently established management information systems, where possible.

Key Factors
This is a brief description of the key factors (up to 3) that may impact (positively or negatively) on the applicant's progress on each of the Health Care and Business Plans' performance measures.

Major Planned Actions
This is a brief description of the major planned actions (up to 2) to be completed in response to the key factors identified in the Key Factors section impacting performance on the Health Care and Business Plans' measures.

Comments/Notes
Supplementary information, notes, context for related entries in the plan may be provided, as applicable.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration **SAMPLE** HEALTH CARE PLAN MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Project Period Date	01/01/2010 - 12/31/2014

Focus Area: Diabetes			
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent			
Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Project Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%		
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.		
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria		
Baseline Data	**Baseline Year:** 2008 **Measure Type:** Percentage **Numerator:** 1700 **Denominator:** 4000	Projected Data (by End of Project Period)	65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2009).		
Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable		

	Key Factor Description: XYZ offers a variety of pharmaceutical assistance programs, including the provision of free, discounted, or generic medications as well as medications through its 340B Federal Drug Pricing arrangement. At least 70% of diabetic patients are on 3 to 8 medications because of co-morbidity complications that occur. **Major Planned Action Description:** Increase education and outreach efforts to diabetic patients on the importance of daily testing and the availability of free/discounted glucometers and test strips available through XYZ.
Key Factor and Major Planned Action #2	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** XYZ has an agency-wide, multidisciplinary team that includes physicians, nurses, medical assistants, a quality management coordinator and a data specialist. The team works with each site to analyze and improve the internal processes to achieve effective diabetes care delivery. **Major Planned Action Description:** At each site, XYZ will identify a physician champion who will be allotted administrative time to work with fellow staff to test and implement changes. The agency-wide and site-specific teams will form a collaborative infrastructure that provides diabetic patients with the necessary tools and support to successfully manage their disease.
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [x] Restricting [_] Not Applicable **Key Factor Description:** Time management becomes problematic when XYZ staff juggles regular work with Diabetes Collaborative tasks. The agency-wide team would like to meet more frequently, but providers are pressed for administrative time given their full clinical schedules. Any type of backlog or deficiency adds system stress to a provider or staff member's work schedule that negatively affects patient care management. **Major Planned Action Description:** Hire an additional clinical staff person to provide additional "non-clinical" review time for the agency-wide team members.
Comments	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration **SAMPLE** BUSINESS PLAN MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ	00001
	Project Period Date	01/01/2010 - 12/31/2014
Focus Area: Costs		
Performance Measure: Medical Cost per Medical Visit		
Is this Performance Measure Applicable to your Organization?	Yes	
Target Goal Description	By the end of the Project Period, maintain rate of increase not exceeding 5%	

	per year, such that medical cost per medical visit is less than or equal to 149.51.		
Numerator Description	Total accrued medial staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist vists)		
Baseline Data	**Baseline Year:** 2008 **Measure Type:** Ratio **Numerator:** 492000 **Denominator:** 4000	Projected Data (by End of Project Period)	149.51
Data Source & Methodology	UDS		
Key Factor and Major Planned Action #1	**Key Factor Type:** [x] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** Recent addition of nurse practitioner providers increased XYZ encounters. **Major Planned Action Description:** Continue assessing current patient/provider mix to best utilize resources.		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [X] Restricting [_] Not Applicable **Key Factor Description:** Recently lost our pediatrician to a local competitor, therefore child visits are down. **Major Planned Action Description:** We are beginning efforts to recruit a NHSC loan repayor to address the shortage.		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration HEALTH CARE PLAN	FOR HRSA USE ONLY	
	Grantee Name	Application Tracking Number
	Project Period Date	

Focus Area: Diabetes	
Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent	
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No
Target Goal Description	
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria

Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Cardiovascular Disease			
Performance Measure: Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Patients 18 to 85 years with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg.		
Denominator Description	All patients 18 to 85 years of age as of December 31 of the measurement year with diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable		

#3	**Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Cancer			
Performance Measure: Percentage of women age 21-64 who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Number of female patients 24 – 64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.		
Denominator Description	Number of female patients age 24-64 years of age during the measurement year who were seen for a medical encounter at least once during 2009 and were first seen by the grantee before their 65th birthday.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Prenatal and Perinatal Health			
Performance Measure: Percentage of pregnant women beginning prenatal care in first trimester			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	All female patients who received perinatal care during the measurement year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider.		
Denominator Description	Number of female patients who received prenatal care during the measurement year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first		

	visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Prenatal and Perinatal Health			
Performance Measure: Percentage of births less than 2,500 grams to health center patients.			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Women in the "Universe" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery.		
Denominator Description	Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable		

	Key Factor Description: **Major Planned Action Description:**		
Comments			
Focus Area: Child Health			
Performance Measure: Percentage of children with 2nd birthday during the measurement year with appropriate immunizations.			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Number of children in the "universe" who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella) and 4 Pneumoccocal conjugate, prior to or on their 2nd birthday whose second birthday occurred during the measurement year (prior to 31 December), among those children included in the denominator.		
Denominator Description	Number of children with at least one medical encounter during the reporting period, who had their second birthday during the reporting period, who did not have a contraindication for a specific vaccine, who were seen for the first time in the clinic prior to their second birthday, regardless of whether or not they came to the clinic for vaccinations or well child care.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Behavioral Health			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:**	Projected Data (by	

	Measure Type: **Numerator:** **Denominator:**	End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Oral Health			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Other			

Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration BUSINESS PLAN	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	Project Period Date	

Focus Area: Costs			
Performance Measure: Total cost per patient			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Total accrued cost before donations and after allocation of overhead		
Denominator Description	Total number of patients		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	

Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Costs			
Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Financial Viability			

Performance Measure Description: Change in Net Assets to Expense Ratio			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Ending Net Assets - Beginning Net Assets		
Denominator Description	Total Expense		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Financial Viability			
Performance Measure: Working Capital to Monthly Expense Ratio			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Current Assets - Current Liabilities		
Denominator Description	Total Expense / Number of Months in Audit		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:**		

	Major Planned Action Description:		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Financial Viability			
Performance Measure: Long Term Debt to Equity Ratio			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Long Term Liabilities		
Denominator Description	Net Assets		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action #1	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**		
Comments			
Focus Area: Other			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Key Factor and Major Planned Action	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable		

#1	**Key Factor Description:** **Major Planned Action Description:**
Key Factor and Major Planned Action #2	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**
Key Factor and Major Planned Action #3	**Key Factor Type:** [_] Contributing [_] Restricting [_] Not Applicable **Key Factor Description:** **Major Planned Action Description:**
Comments	

Instructions and Format for Annual Recertification Health Care and Business Plans
Applications for annual recertification must summarize progress towards the goals established in the most recently approved initial/renewal of designation application. Use the sample annual recertification application Health Care and Business Plan formats provided in this appendix. Do not submit the original Health Care and Business Plans submitted with the most recent initial/renewal of designation application. Refer to Section III.6.Criterion 3 - Evaluative Measures, for the specific elements that must be addressed in the Health Care and Business Plan updates. The Plans collectively should not exceed 10 pages.

NOTE: Organizations that have not submitted a renewal of designation application with a five-year Health Care and Business Plan must do so in this recertification application. Please follow the instructions for preparing an Initial/Renewal of Designation Health Care and Business Plan above. Organizations should contact the Office of Policy and Program Development (301-594-4300 or OPPDGeneral@hrsa.gov) for additional guidance.

Need Addressed/Focus Area
This is a concise categorization of the major need or focus area to be addressed by the applicant for their service area, target population and/or organization to be addressed (Diabetes; Cardiovascular Disease; Costs, Productivity, etc.). Applicants are expected to address each required performance measurement area (as described in the table below), as well as any other key needs of their target population or organization as identified in the application narrative.

Project Period Goal(s) with Baseline
Goals are relatively broad statements relating to the Need Addressed/Focus Area. Applicants should provide goals which, where possible, can be accomplished by the end of the multi-year project period. The goal should be reasonable, measurable, and reflect an anticipated impact upon the specified need or focus area. The applicant must also provide baseline data (where possible) to indicate their status at or prior to the beginning of the project period.

Note that for some FQHC Look-Alikes this may mean several years ago. But for FQHC Look-Alikes in the first year of a new project period, it will mean the value of the most recent reporting year. Baseline data provides a basis for quantifying the amount of growth/change to be accomplished in the project period. If applicants choose to establish a baseline for any of the new Health Care Plan measures, they are encouraged to utilize the sampling/chart review instructions provided in the 2009 Uniform Data System Reporting Manual, available at http://www.bphc.hrsa.gov/uds/2008manual/default.htm. Applicants are expected to track performance against these goals throughout the entire approved project period and to report progress achieved on the goal in this and subsequent annual recertification applications. However, project period end goals can be revised if major accelerated progress or barriers have been experienced in the previous recertification period. The rationale and comments for any revisions must be provided in the Progress towards Goal section of the Health Care or Business Plan and/or Program Narrative, as applicable.

Applicants that included additional goals and performance measures in their most recent initial/renewal of designation application must also report progress on these goals. In cases where data on the new clinical performance measures was not previously collected by the organization, these should be listed as "Data Not Available."

Progress towards Goal (Report 3-Year Trend - Quantitative)
Report quantitative progress on the related performance measures, including all required measures, stated in the applicant's most recent initial/renewal of designation application. Applicants should report progress in terms of trends (e.g., % increase or decrease) based on the most recent three-years of complete data if such data are available. Additional measures chosen by the applicant should also define the numerator and denominator[29] that will be used to determine the level of progress/improvement achieved on each goal (e.g., Numerator: One or more screenings for colorectal cancer. Denominator: All patients age 51-80 years during the measurement year).

Progress towards Goal (Qualitative)
Describe qualitative progress, such as major processes, strategies or objectives achieved to date that contribute to the achievement of the goal. Also, include any significant changes in the contributing and/or restricting factors impacting the FQHC Look-Alike's performance on the measure as well as any significant changes in the key actions or major planned responses to these factors.

Note: Detailed narrative regarding contributing or restricting factors affecting progress on the Health Care or Business Plan should be included in the Evaluative Measures section of the Program Narrative, as appropriate.

[29] When used here, "denominator" means the universe of patients who fit the criteria. It is assumed that most FQHC Look-Alikes will measure these ratios by using a scientifically drawn sample.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration **SAMPLE** HEALTH CARE PLAN MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ Health Center	00000
	Project Period Date	01/01/2010 - 12/31/2014

Focus Area: Diabetes

Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent

Is this Performance Measure Applicable to your Organization?	Yes		
Target Goal Description	By the end of the Project Period, increase the % of adult patients with type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is ≤ 9% (under control) up to 65%		
Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.		
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria		
Baseline Data	**Baseline Year:** 2008 **Measure Type:** Percentage **Numerator:** 1700 **Denominator:** 4000	Projected Data (by End of Project Period)	65%
Data Source & Methodology	Representative sample of patient records. (Data run on 1/10/2009).		
Progress Toward Goal	**Quantitative:** 53.6%		
	Qualitative: We had an 11% improvement in performance on this measure compared to our baseline and are well on our way to addressing our goal of 65% by the end of the project period. The main contributor to our success this year was the implementation of physician champions across all of our sites who allotted administrative time to work with fellow staff to test and implement changes to our diabetes management protocols. The agency-wide and site-specific teams formed a collaborative infrastructure that provided diabetic patients with the necessary tools and support to successfully manage their disease. We plan to continue our work with the physician champions and further improve performance by developing an incentive plan that rewards providers to improve their patients' health outcomes.		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration **SAMPLE** BUSINESS PLAN MEASURE	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	XYZ	00001
	Project Period Date	01/01/2010 - 12/31/2014

Focus Area: Costs

Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	Yes		
Progress Toward Goal	By the end of the Project Period, maintain rate of increase not exceeding 5% per year, such that medical cost per medical visit is less than or equal to 149.51.		
Numerator Description	Total accrued medial staff and medical other cost after allocation of overhead (excludes lab and x-ray costs)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	**Baseline Year:** 2008 **Measure Type:** Ratio **Numerator:** 492000 **Denominator:** 4000	Projected Data (by End of Project Period)	149.51
Data Source & Methodology	UDS		
Progress Toward Goal	**Quantitative:** 127.01		
	Qualitative: We experienced a 3.3% increase in our medical cost per medical visit. During the middle of the year we were able to hire a nurse practitioner who works in two of our sites. The addition of the nurse practitioner has increased the overall number of medical visits to the health center. We plan to continue to review our staffing mix to ensure we are staffed in a manner that maximizes our productivity and supports our goal of cost increases minimal.		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration HEALTH CARE PLAN	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	Project Period Date	

Focus Area: Diabetes

Performance Measure: Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent	
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No
Target Goal Description	

Numerator Description	Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.		
Denominator Description	Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Cardiovascular Disease			
Performance Measure: Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Patients 18 to 85 years with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg.		
Denominator Description	All patients 18 to 85 years of age as of December 31 of the measurement year with diagnosis of hypertension before June 30 of the measurement year and have been seen at least twice during the reporting year.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Cancer			
Performance Measure: Percentage of women age 21-64 who received one or more Pap tests during the measurement year or during the two years prior to the measurement year.			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Number of female patients 24 – 64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.		

Denominator Description	Number of female patients age 24-64 years of age during the measurement year who were seen for a medical encounter at least once during 2009 and were first seen by the grantee before their 65th birthday.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Prenatal and Perinatal Health			
Performance Measure: Percentage of pregnant women beginning prenatal care in first trimester			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	All female patients who received perinatal care during the measurement year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider.		
Denominator Description	Number of female patients who received prenatal care during the measurement year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Prenatal and Perinatal Health			
Performance Measure: Percentage of births less than 2,500 grams to health center patients.			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description	Women in the "Denominator" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery.		
Denominator Description	Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery.		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			

Focus Area: Child Health			
Focus Area: Behavioral Health			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Oral Health			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Other			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Target Goal Description			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration BUSINESS PLAN	FOR HRSA USE ONLY	
	Organization Name	Application Tracking Number
	Project Period Date	

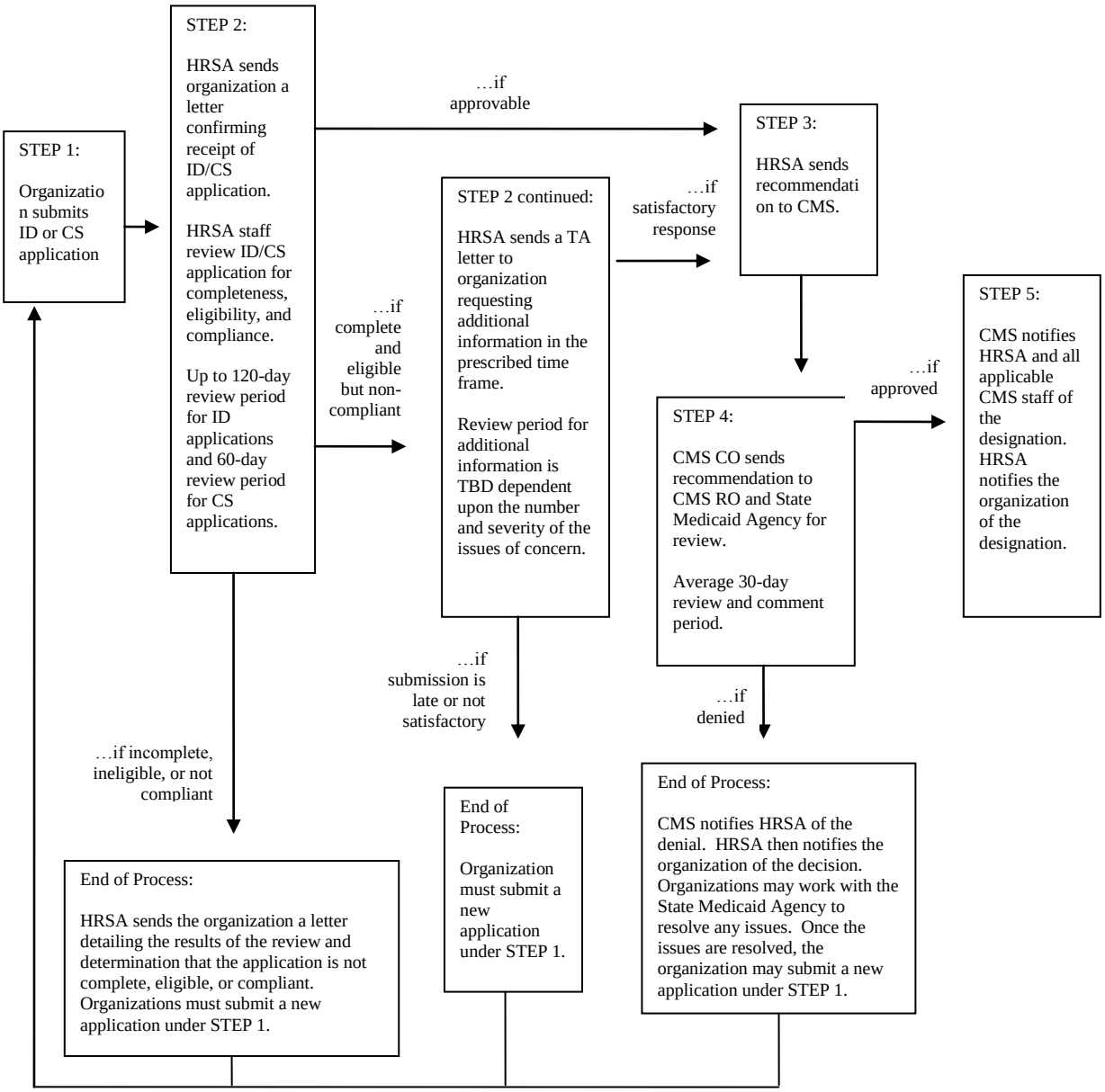
Focus Area: Costs			
Performance Measure: Total cost per patient			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Progress Toward Goal			
Numerator Description	Total accrued cost before donations and after allocation of overhead		
Denominator Description	Total number of patients		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			

Focus Area: Costs			
Performance Measure: Medical Cost per Medical Visit			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Progress Toward Goal			
Numerator Description	Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost)		
Denominator Description	Non-nursing medical visits (excludes nursing (RN) and psychiatrist visits)		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			

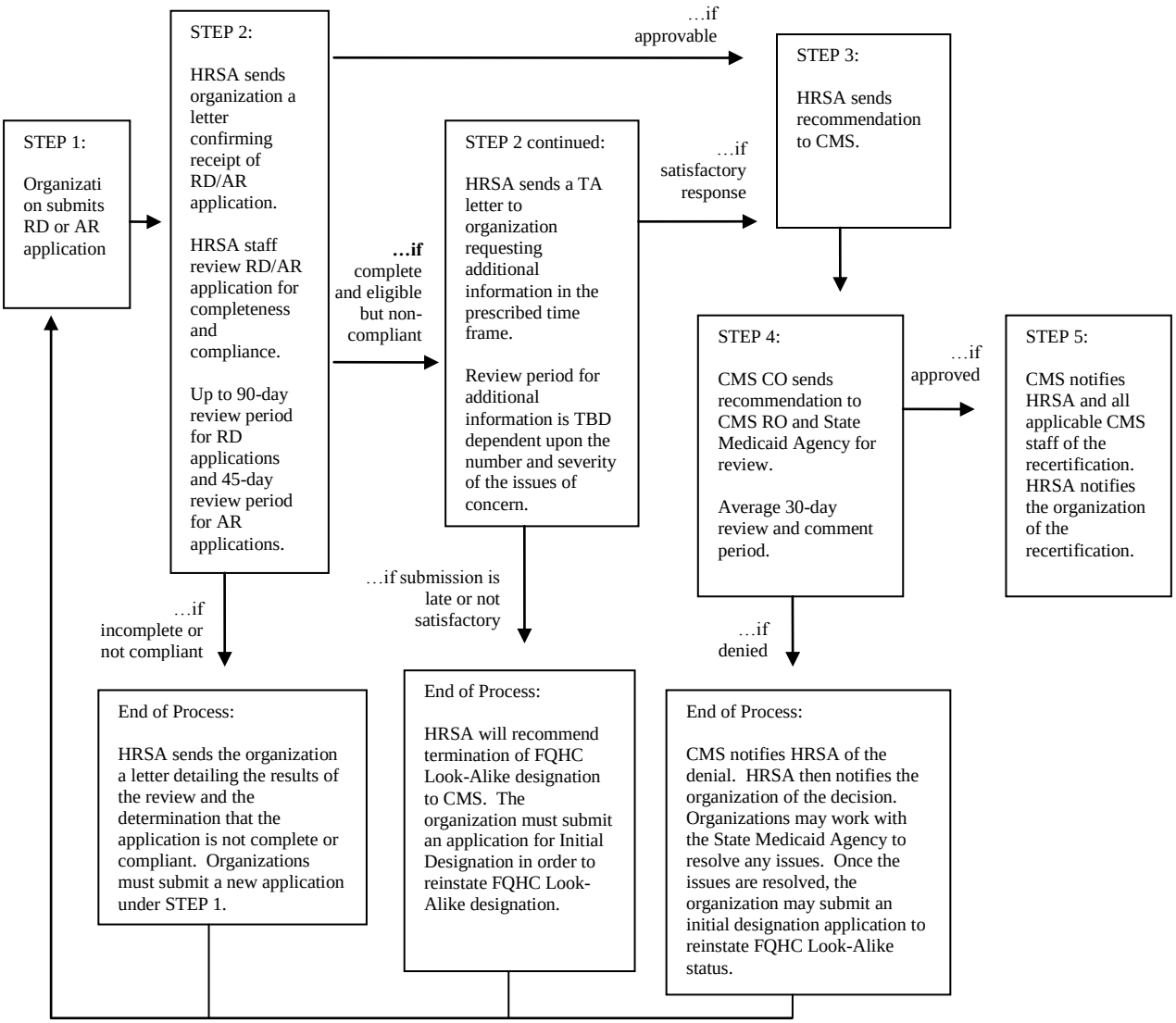
Focus Area: Financial Viability			
Performance Measure Description: Change in Net Assets to Expense Ratio			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Progress Toward Goal			
Numerator Description	Ending Net Assets - Beginning Net Assets		
Denominator Description	Total Expense		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		

	Qualitative:		
Comments			
Focus Area: Financial Viability			
Performance Measure: Working Capital to Monthly Expense Ratio			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Progress Toward Goal			
Numerator Description	Current Assets - Current Liabilities		
Denominator Description	Total Expense / Number of Months in Audit		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Financial Viability			
Performance Measure: Long Term Debt to Equity Ratio			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Progress Toward Goal			
Numerator Description	Long Term Liabilities		
Denominator Description	Net Assets		
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			
Focus Area: Other			
Performance Measure:			
Is this Performance Measure Applicable to your Organization?	[_] Yes [_] No		
Progress Toward Goal			
Numerator Description			
Denominator Description			
Baseline Data	**Baseline Year:** **Measure Type:** **Numerator:** **Denominator:**	Projected Data (by End of Project Period)	
Data Source & Methodology			
Progress Toward Goal	**Quantitative:**		
	Qualitative:		
Comments			

Appendix F: Flow Chart of Initial Designation (ID) and Change in Scope (CS) Application Review Process



Appendix G: Flow Chart of Renewal of Designation (RD) and Annual Recertification (AR) Application Review Process



Appendix H: Tips for Developing a High Quality Application

1. Common Mistakes

The HRSA has identified the following common mistakes in many FQHC Look-Alike application submissions. The mistakes are broken down by each section of the application.

Overall:

- Organization did not meet the eligibility requirements.
- Organization did not demonstrate compliance with all program requirements.
- Inconsistencies exist between the application narrative and data forms.
- Application did not include all of the required forms and attachments.
- Application did not correctly complete the required forms.

Eligibility requirements:

- Organization was owned, operated or controlled by another entity.
- Organization did not have non-profit status.

Need and community impact requirements:

- Organization was not serving, in whole or in part, a MUA/MUP.
- Organization's service area was not clearly defined.
- Service area overlap existed with an existing FQHC.
- Application contained no discussion of other providers.
- Application data tables did not align with the program narrative and/or organizational chart.

Health services requirements:

- Application did not contain signed contracts.
- Organization did not have after-hours coverage.
- Organization did not have a sliding fee scale.
- Organization did not offer case management.

Management and finance requirements:

- Organization did not comprehensively discuss lines of authority.
- Organization's structural chart lacked the names and FTEs of staff.
- Organization did not have a MIS system in place.
- Application did not contain a recent audit.
- Organization did not possess Medicare and Medicaid provider numbers by site to demonstrate its operational status.

Governance requirements:

- Organization's governing board had non-compliant bylaws.
- Organization's co-applicant agreement was not clearly written.
- Governing board bylaws did not contain a conflict of interest policy.

2. Tips for Success

The HRSA suggests that organizations for FQHC Look-Alike designation review the following tips for a successful application:

Start Early:

- Work with partners to demonstrate that you are coordinating services in the community with other providers of care. Work with other FQHCs in the area. Organizations should refer to PIN 2007-09, "Service Area Overlap: Policy and Process," for guidance on how to prepare a service area overlap analysis.
- Get technical assistance from your PCA, PCO, other State or national organizations, or other experienced health centers.
- Review, Review, and Review the application. It is also a good idea to have an independent reviewer look at the application.
- Use feedback from HRSA staff and technical assistance letters to improve applications.

Follow Instructions:

- Pay attention to the detailed instructions in the application and HRSA policies.
- Submit complete applications by making sure that all requested documents are included.

Be Responsive:

- Clearly show that the organization is compliant with each program requirement.
- Check to make sure the information in the application program narrative and data tables is consistent.

Appendix I: Form and Table Instructions

Applications for the FQHC Look-Alike Program must contain all required forms as identified in Section III.3., Application Content and Format. Please download and complete each required form based on the type of application. Please note that only these forms which are available via this application, approved by the U.S. Office of Management and Budget, should be submitted with the application.

- **FORM 1, PART A – GENERAL INFORMATION WORKSHEET**
  Form 1 – Part A provides a summary of information related to the project at the time of application submission. The following instructions are intended to clarify the information to be reported in each section of the form.

  1. Organization Information: Complete all information as requested.
  2. Service Area
     a. Service Area Designation: Select the designation(s) which best describe the proposed service area. Multiple selections are allowed. Identify the type of population served by the organization. For inquiries regarding Medically Underserved Areas of Medically Underserved Populations, call 1-888-275-4772. Press option 1, then option 2 or contact the Shortage Designation Branch via email sdb@hrsa.gov or 301-594-0816. For additional information, visit the HRSA Bureau of Health Professions Shortage Designation web site at http://bhpr.hrsa.gov/shortage/.
     b. Target Population Type: Classify target population type as Rural or Urban.
     c. Target Population and Provider Information: For all portions of this section, organizations with more than one delivery site should report aggregate data for all of the sites included in the project.
        - *Service Area and Target Population:* Provide the estimated number of individuals composing the service area and target population currently and the estimated numbers proposed by end of the project period ("Projected at Full Capacity").
        - *Provider FTEs by Type:*
          1. Identify a count of billable provider FTEs by type (i.e., medical providers, dental providers, behavioral health providers, and substance abuse services providers).
          2. "Projected at Full Capacity" refers to the number of FTEs anticipated by the organization by the end of the project period (up to five years).
          3. Do not report provider FTEs outside the organization's proposed scope of project or any volunteer providers.
        - *Total Unduplicated Patients and Visits by Service Type:*
          1. Identify the current number of unduplicated patients and visits for each service type and the projected number of patients and visits at full capacity. "Projected at Full Capacity" refers to the number of patients and/or visits anticipated to be served by the organization by the end of the project period (up to five years).
          2. Organizations are encouraged to sustain and/or increase patients and/or visits through the project period. Organizations should explain any declines in the

number of patients and/or visits over the project period in the program narrative.

3. Do not report patients and visits for services outside the organization's approved scope of project.

- *Unduplicated Patients and Visits by Population Type:*
  1. Identify the current number of patients and visits by population type.
  2. Renewal of designation applications should use this section to identify the number of patients seen throughout each year of the project period. (For example, if reporting for the second year of the project period, enter the total amount of patients seen during the second year in the column d, current number. Enter the number of patients served during the previous year in "Number at end of Year 1," and so forth).
  3. **NOTE**: When providing an unduplicated count of patients and visits please note the following guidelines:
     - Visits are defined as documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented in the patient's record.
     - Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

- **FORM 1, PART C – DOCUMENTS ON FILE**
  Provide the date each document was last revised.

- **FORM 3 – INCOME ANALYSIS**
  Each organization must complete the Income Analysis Form. The form projects program income, by source, for the first year of the project period.

  The Income Analysis Form provides a format for presenting the estimated non-Federal revenues and other sources of income for the organization. Any specific entries that require additional explanation should be discussed in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form and if necessary, detailed in the Management and Finance program narrative. The worksheet must be based on the proposed project. It may not include any grant funds from any pending grants or other unapproved changes in sites, services or capacity. There are two major classifications of revenues, Program Income and Other Income.

  - **Part 1: Program Income** includes fees, premiums and third party reimbursements and payments generated from the projected delivery of services. Program income is divided into two types of income: Fee for Service and Capitated Managed Care.

  - **Part 2: Other Income** includes State, Local or other Federal grants (e.g., Ryan White, HUD, Head Start, etc.) or contracts and local or private support that is not generated from charges for services delivered.

  If the categories in the worksheet do not describe all possible categories of Program or Other Income, such as "pharmacy", organizations may add lines for any additional income source if

necessary. Clarifications for these additions may be noted in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form.

Part 1: Program Income

This form reports only on those visits which are billable to first or third parties including individuals who, after the schedule of discounts/sliding fee scale, may pay little or none of the actual charge.

Projected Fee for Service Income

Lines 1a.-1e. and 2a. – 2b (Medicaid and Medicare): Show income from Medicaid and Medicare regardless of whether there is another intermediary involved. For example, if the organization has a Blue Cross fee-for-service managed Medicaid contract, the information would be included on lines 1a.-1e., not on lines 3a.-3c. If the Child Health Insurance Program (CHIP) is paid through Medicaid, it should be included in the appropriate category on lines 1a-1e. In addition, if the organization receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income should be included on line 1e. "Medicaid: Other Fee for Service."

Line 5 (Other Public): Include here any CHIP reimbursement not paid through the Medicaid Program as well as any other State or local programs that pay for visits including Title X family planning visits, CDC's Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits, etc.

Column (a): Enter the number of billable visits that will be covered by each category and payment source: Medicaid, Medicare, other third-party payors and uninsured self-pay patients.

Column (b): Enter the average charge per visit by payor category. A sophisticated analysis of charges will generally reveal different average charges; for example, Medicare charges may be higher than average Medicaid EPSDT charges. If this level of detail is not available, averages may be calculated on a more general level (i.e., at the payor or service type or agency level).

Column (c): Enter Total Gross Charges before any discount or allowance for each payment category calculated as [columns (a)*(b)].

Column (d): Enter the average adjustment to the average charge per visit in column (b).

A negative number reduces and a positive number increases the Net Charges calculated in column (e). (In actual operation, adjustments may be taken either before or after the bill is submitted to a first or third party.) Adjustments reported here do not include adjustments for bad debts. These are shown in column f and g. Adjustments in column (d) include those related to:

a) Projected contractual allowances or discounts to the average charge per visit.

b) Sliding discounts given to low-income patients (with incomes 0 to 200% of the Federal poverty guidelines as applicable).
c) Adjustments to bring the average charge up/down to the negotiated FQHC or PPS established reimbursement rate or the cost based reimbursement expected after completion of a cost reimbursement report.
d) Any other applicable adjustments. These should be discussed in the "Comments/Explanatory Notes" box at the bottom of page 2 of the form.

Column (e): Enter the total Net Charges by payment source calculated as [columns c-(a*d)]. Net charges are gross charges less adjustments described in column d.

Column (f): Based on previous experience, enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source. Explain any rate greater than 100% using the "Comments/Explanatory Notes" section of the form. **NOTE:** Do not show sliding discount percentages here – they are included above in column (d); do show the collection rate for actual direct patient billings.

Column (g): Enter Projected income for each payor category calculated as: column (e) * column (f).

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available. Any significant variance between projected income (columns g) and actual accrued income (column h) should be explained in the Management and Finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Projected Capitated Managed Care Income

This section applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service section of this Form. Note also, that unlike the fee-for-service section of this Form, organizations will group together all types of services on a single line for the type of payor. Thus, Capitated Medicaid dental visits and Capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): "Member months" are the number of member months for which the organization receives payment. One person enrolled for one month is one member month; a family of five enrolled for six months is 30 member months. A member month may cover just medical services or medical and dental or an even more unique mix of services. Unusual service mixes which provide for unusually high or low per-member per-month (PMPM) payments should be described in the notes section.

Rate per Member Month (Column b): Also referred to as PMPM rate. This is the

average payment across all managed care contracts for one member. PMPM rates may actually be based on multiple age/gender specific rates or on service specific plans, but all these should be averaged together for a "blended rate" for the provider type.

Risk Pool Adjustment (Column c): This is an estimate of the total amount that will be earned from risk or performance pools. It includes any payment made by the HMO to the organization for effectively and efficiently managing the health care of the enrolled members. It is almost always for a prior period, but must be accounted for in the period it is received. Describe risk pools in the narrative. Risk pools may be estimated by using the average risk pool receipt PMPM over an appropriate prior period selected by the organization.

FQHC and Other Adjustments (Column d): This is the total amount of payments made to the organization to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the organization's PPS/FQHC rate.

Projected Gross Income (Column e): Column e is calculated for each line as: [column (a)* column (b)] + [column c + column d] = e.

Actual Gross Income (Column f): Identify the actual gross income the organization accrued for the most recent 12-month period. Any significant variance between projected income (columns e) and actual accrued income (column f) should be explained in the Management and Finance program narrative portion of the application. If 12-months of data are not available, enter the amount available and indicate the time frame.

Part 2: Other Income

This category includes all other income not entered elsewhere on this table. It includes grants for services, construction, equipment or other activities that support the project, where the revenue is not generated from services provided or visit charges. It also includes income generated from fundraising and contributions, foundations, etc.

Line 9. "Applicant" refers to any income generated by the organization through the expenditure of its own assets such as income from reserves or realized sale of property.

Please note that in-kind donations should not be included in the Income Analysis; however organizations may discuss in-kind contributions as applicable, in the Management and Finance program narrative.

- **FORM 4 – COMMUNITY CHARACTERISTICS**
  The Community Characteristics form reports service area and target population data for the entire scope of the project (i.e., all sites) for the most recent period for which data are available. Service area data should be specific to the project. Target population data should reflect the total target population the organization serves. If information for the service area is not available, utilize data from U.S. Census Bureau, local planning agencies, health departments and other local, State, and national data sources. Estimates are acceptable.

When completing Form 4 - Community Characteristics, please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will not be used as a factor for recommending FQHC Look-Alike designation.

Please Note New Categories for reporting on Racial and Ethnic composition of the Service Area and/or Target Population:

***Race*:**
In completing the form, organizations are required to report race for all individuals served; however, some patient registration systems are configured to capture data for patients who were asked to report race or ethnicity. Organizations that are unable to distinguish a White Latino patient from a Black Latino patient (because the MIS only identifies patients as White, Black or Latino), should report these patients as "unreported." In the table in Form 4, the total number of individuals in the "Hispanic or Latino Identity" total must equal the total number of individuals in the "Race" total.

- Report the number of individuals in each racial category.
- All individuals must be classified in one of the racial categories (including "Unreported / refused to report"). This includes individuals who self-report to be "Latino" or "Hispanic." If the organization's MIS does not separately classified these individuals by race, then report "Latino" and "Hispanics" as "race unreported."
- Individuals are further divided on the Race table into separate ethnic categories:
    - Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
    - Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, or other Pacific Islands.
    - Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
    - American Indian/Alaska Native should be considered to include persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- Note the addition of "More than one race." Use this line *only* if the individual has chosen two or more races.

Hispanic or Latino Identity (Ethnicity):

- Report on the "Hispanic or Latino" line persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- If the individual is not a member of one of the cultures or origins listed in the bullet above then include these individuals in the "All others including unreported" line.

- **FORM 5, PART A – SERVICES PROVIDED**
  Organizations must identify what services are available at the site(s) for the entire organization and how these services will be provided. Only one form is required for the

services provided by the entire organization at all sites. Refer to PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes," for more information on defining services. Only those services identified on Form 5 Part A will be documented as a part of the organization's scope of project. Services that are identified elsewhere in the application (e.g., program narrative) and are not identified on Form 5 Part A will not be considered to be in the approved scope of project.

FQHC Look-Alikes may only include those services that are included under the approved scope of project and may not request to add/delete a service in the annual recertification or renewal of designation application. Organizations must submit a change in scope application to add/delete a service.

- **FORM 5, PART B – SERVICE SITES**
  Organizations must identify the name and address of each service site that meets the definition of a site (see Appendix B for a definition of service site). Refer to PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes," for more information on defining sites and for special instructions for recording mobile, intermittent or other site types. Only those sites identified on Form 5 Part B will be documented as a part of the organization's scope of project. Sites that are identified elsewhere in the application (e.g., program narrative) and are not identified on Form 5 Part B will not be considered to be in the approved scope of project.

  FQHC Look-Alikes may only include those service sites that are included under the approved scope of project and may not request to add/delete/relocate a site in the recertification or renewal application. Organizations must submit a change in scope application to add/delete/relocate a site.

- **FORM 5, PART C – OTHER ACTIVITIES/LOCATIONS (AS APPLICABLE)**
  "Other activities/locations" are considered activities that are provided at locations that: (1) do not meet the definition of a service site; (2) are conducted on an irregular time frame/schedule; and/or, (3) offer a limited activity from within the full complement of health center activities included within the scope of project. Organizations must identify all "other activities," their locations, estimated frequency and a brief description of the activity using this form. For additional guidance on "other activities/locations," refer to PIN 2008-01, "Defining Scope of Project and Policy for Requesting Changes."

  FQHC Look-Alikes are not required to obtain prior approval from HRSA to add/delete/relocate an "other activity/location"; however, they should submit a revised Form 5 – Part C when changes are made.

- **FORM 6, PART A – CURRENT BOARD MEMBER CHARACTERISTICS**
  Organizations must list all current board members and provide information on all characteristics as requested.

- **FORM 6, PART B – REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS (AS APPLICABLE)**

Form 6 - Part B may only be submitted by organizations requesting FQHC Look-Alike designation to serve a special population authorized under section 330 of the PHS Act (i.e., MSAWs (section 330(g)), homeless populations (section 330(h)) and/or residents of public housing (section 330(i)). Organizations that serve the general community (i.e., section 330(e)), or the general community in conjunction with a special population, are not eligible for a governance waiver. Please refer to Section II, Eligibility and Program Requirements, for additional information on governance waivers.

- **FORM 8 – HEALTH CENTER AFFILIATION CERTIFICATION/CHECKLIST**
  Submission of Form 8 is required for FQHC Look-Alikes designated to serve the general community (section 330(e)) and/or MSAWs (section 330(h)). Indicate whether any of the identified affiliation arrangements are currently present or proposed and the entity with which the organization has the affiliation arrangement. Complete the checklist as applicable. This information will be used to assure that organizations receiving FQHC Look-Alike designation are compliant with the requirements and guidelines set forth in PINs 97-27, "Affiliation Agreements of Community and Migrant Health Centers," and 98-24, "Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers." A copy of all subrecipient arrangements, contracts, and affiliations agreements should be included in the application.

- **FORM 10 – ANNUAL EMERGENCY PREPAREDNESS (EP) REPORT**
  The Annual Emergency Preparedness Report will be used to assess the status of emergency preparedness planning, progress towards developing and implementing an emergency management plan.

- **FORM 12 - CONTACT INFORMATION**
  This form has been added to the application package to capture the right contact points with the organization to initiate communication when required.

- **ELECTRONIC HEALTH RECORDS INFORMATION**
  Please complete the form indicating whether or not an electronic system is maintained by the organization and integrated within an Electronic Health Record (EHR). When completing this form, please note that all information provided will be used only to collect data and will not be used as a factor for determining FQHC Look-Alike designation. All organizations should complete questions 1 and 4. Questions 2 and 3 are required if the organization uses an electronic system.

  Question 1 – All organizations should complete question 1 based on the current system used at the time of application submission. If the organization does not use an electronic system, please skip questions 2 and 3.

  Question 2 – EHR Certification: Commission of Healthcare Information Technology (CCHIT) certified. Please check "Yes" if your system is certified by a certification body recognized by the U.S. Department of Health and Human Services. For reference, please visit the CCHIT web site at http://www.cchit.org/choose/index.asp. Any certification year is

considered certified for the purposes of this survey. Please check "No" if it is not certified. Only check "N/A" if you do not have a medical system.

Question 3 – This is a two part question. The organization should make (1) the appropriate check box selection of the clinical programs that use an electronic system and (2) those that are integrated within the health center's EHR by checking the appropriate box in column 2 (Integrated into EHR).

Question 4 – This question should be completed by all applicants.

- **TABLE 3A AND 3B – PATIENTS BY AGE, GENDER, ETHNICITY, RACE, AND LANGUAGE**

  Tables 3A and 3B provide demographic data on patients of the program. Identify all individuals receiving at least one face-to-face visit over the previous 12-months for services which are within the scope of the program. Regardless of the number or types of services received, each patient is to be counted only once on Table 3A, once in the race/ethnicity section of Table 3B and once in the language section of Table 3B.

  A visit is a face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient, and the services rendered must be documented to be counted as a visit. See Appendix B, Glossary, for complete definitions of patients and visits.

  When completing Table 3A and 3B, please note that all information provided regarding race and ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will not be used as a factor for recommending FQHC Look-Alike designation.

  Table 3A: Patients by Age and Gender

  Report the number of total patients by appropriate categories for age and gender. For reporting purposes, use the individual's age on June 30 of the reporting period.

  Table 3B: Patients by Ethnicity, Race, and Language

  HISPANIC OR Latino Identity (Ethnicity):

  - Report the number of patients in each category. The total on Table 3B line 4 must equal the total on Table 3A, line 39 Columns A + B.
  - This table collects information on whether or not patients consider themselves to be of Latino or Hispanic identity. Report on line 1 persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

  RACE:

  - Report the number of patients in each racial category. The total on Table 3B line 11 must equal the total on Table 3A, line 39 Columns A + B.
  - All patients must be classified in one of the racial categories (including "Unreported / refused to report"). This includes individuals who also consider themselves to be

"Latino" or "Hispanic". If your data system has not separately classified these individuals by race, then report them all on line 10 as "race unreported."

- Patients are further divided on the Race table into three separate ethnic categories:
    - 5b. Native Hawaiian – Persons having origins in any of the original peoples of Hawaii.
    - 5c. Other Pacific Islanders – Persons having origins in any of the original peoples of Guam, Samoa, or other Pacific Islands.
    - Line 5. " Hawaiian / Pacific Islander", must equal lines 5b + 5c.
    - 5a. Asian – Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "American Indian"/Alaska Native (line 7) should be considered to include persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- "More than one race" (line 9a). Use this line only if your system captures multiple races (but not a race and an ethnicity!) and the patient has chosen two or more races. This is usually done with an intake form which lists the races and tells the patient to "check one or more."

Note: Organizations are required to report race and ethnicity for all patients; however, some patient registration systems are configured to capture data for patients who were asked to report race or ethnicity. Organizations that are unable to distinguish a White Latino patient from a Black Latino patient (because their system only asks patients if they are White, Black or Latino), are instructed to report these patients as "unreported".

LANGUAGE:

- Report on line 12 the number of patients who are best served in a language other than English or with sign language.
- Include those patients who were served by a bilingual provider and those who may have brought their own interpreter.

NOTE: Data reported on line 12, Language, may be estimated if the health center does not maintain actual data in its patient registration system. Wherever possible, the estimate should be based on a sample.

- **TABLE 4 – SELECTED PATIENT CHARACTERISTICS**

Table 4 provides descriptive data on the socioeconomic status of health center patients. Please include all patients receiving at least one face-to-face encounter for services within the scope of services.

NOTE: The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income) and Line 12, Column A + B (patients by insurance status). The sum of Table 3A, Lines 1-20, Columns A + B must equal Table 4, Line 12, Column A. Similarly, total patients reported on the Grant Reports on Tables 3A, 3B and 4 must be equal.

Income as Percent of Poverty Level, Lines 1 - 6
Organizations are expected to collect income data on all patients, but are not required to collect this information more frequently than once during the year. If income information is updated during the year, report the most current information available. Patients for whom the information was not collected within the last year ***must*** be reported on line 5 as unknown. Do not attempt to allocate patients with unknown income. Knowing that a patient is homeless or a migrant or on Medicaid is not adequate to classify that patient as having an income below the poverty level.

Income is defined in ranges relative to the Federal poverty guidelines (e.g., < 100 percentage of the Federal poverty guidelines). In determining a patient's income relative to the poverty level, organizations should use official poverty line guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register in February or March of each year (available at http://aspe.hhs.gov/poverty/08poverty.shtml).

Every patient reported on Table 3A must be reported once (and only once) on lines 1 through 5. The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (patients by income).

Principal Third Party Insurance Source, Lines 7 - 12
This portion of the table provides data on patients by principal source of insurance for primary medical care services. (Other forms of insurance, such as dental or vision coverage, are not reported.) Patients are divided into 2 age groups (Column A) 0 - 19 and (Column B) age 20+. Primary patient medical insurance is divided into seven types as follows:

- S-CHIP (Line 8b or 10b) – The State Child Health Insurance Program (also known as S-CHIP) provides primary health care coverage for children and, on a state by state basis, others – especially parents of these children. S-CHIP coverage can be provided through the state's Medicaid program and/or through contracts with private insurance plans. In some states that make use of Medicaid, it is difficult or even impossible to distinguish between regular Medicaid and S-CHIP-Medicaid. In other states the distinction is readily apparent (e.g., they may have different cards). Where it is not obvious, S-CHIP may often still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information from the state and/or county on their coding practice. If there is no way to distinguish between regular Medicaid and S-CHIP Medicaid, classify all covered patients as "regular" Medicaid. In those states where S-CHIP is contracted through a private third party payor, participants are to be classified as "other public-CHIP" (Line 10b) *not* as private.

- Medicaid (Line 8a, 8b, and 8) – State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the SSA. Medicaid includes programs called by State-specific names (e.g., California's Medi-Cal program). In some states, the State Children's Health Insurance Program (S-CHIP) is also included in the Medicaid program – see above. While Medicaid coverage is generally funded by Federal and State funds,

some states also have “State-only” programs covering individuals ineligible for Federal matching funds (e.g., general assistance recipients) and these individuals are also included on Lines 8a, 8b, and 8. NOTE: Individuals who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the State Medicaid agency should be reported as “Medicaid", not as privately insured.

- Medicare (Line 9) – Federal insurance program for the aged, blind and disabled (Title XVIII of the SSA).

- Other Public Insurance (Line 10a) – State and/or local government programs, such as Washington’s Basic Health Plan or Massachusetts’ Commonwealth plan, providing a broad set of benefits for eligible individuals. Include public paid or subsidized private insurance not listed elsewhere. Do not include any S-CHIP, Medicaid or Medicare patients on this line. Do not include uninsured individuals whose visit may be covered by a public source with limited benefits such as the Early Prevention, Screening, Detection and Treatment (EPSDT) program or the Breast and Cervical Cancer Control Program, (BCCCP), etc. Also do not include persons covered by workers' compensation, as this is not health insurance for the patient, it is liability insurance for the employer.

- Other Public (S-CHIP) (Line 10-b) – S-CHIP programs which are run through the private sector, often through HMOs, where the coverage appears to be a private insurance plan (such as Blue Cross / Blue Shield) but is funded through S-CHIP.

- Private Insurance (Line 11) – Health insurance provided by commercial and non-profit companies. Individuals may obtain insurance through employers or on their own. Private insurance includes insurance purchased for public employees or retirees such as Tricare, Trigon, Veterans Administration, the Federal Employees Benefits Program, etc.

One additional categories are included on Table 4 for patients who are uninsured (line 7).

Every patient reported on Table 3A must be reported once (and only once) on lines 7 through 11. The sum of Table 3A, Line39, Column A + B (total patients by age and gender) must equal Table 4, Line 12 Column A + B (total patients by insurance status).

Specific Instructions for Reporting Patients by Source of Insurance

Organizations should report the patient’s primary health insurance covering medical care, if any, as of the last visit during the reporting period. Principal insurance is defined as the insurance plan/program that the organization would bill first for services rendered. NOTE: Patients who have both Medicare and Medicaid, would be reported as Medicare patients because Medicare is billed before Medicaid. The exception to the Medicare first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the principal health insurance is the employer-based plan, which is billed first.

Patients for whom no other information is available, whose services are paid for by grant programs, including family planning, BCEDP, immunizations, TB control, as well as patients served in correctional facilities, may be classified as uninsured.

Similarly, patients whose services are subsidized through State/local government "indigent care programs" are considered to be uninsured. Examples of state government "indigent care programs" include New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, California's Expanded Assistance for Primary Care, and Colorado Indigent Care Program.

For both Medicaid and Other Public Insurance, the table distinguishes between "regular" enrollees and enrollees in S-CHIP.

Medicaid = Line 8b includes Medicaid-S-CHIP enrollees only; Line 8a includes all other enrollees; and Line 8 is the sum of 8a + 8b.

Other Public = Line 10b includes S-CHIP enrollees who are covered by a plan other than Medicaid; Line 10a includes all other persons with other public insurance (Organizations are asked to describe the programs so HRSA can make sure that the classification of the program as other public is appropriate.); and Line 10 is the sum of 10a + 10b.

Managed Care Utilization, Lines 13a – 13c

This section on "Managed Care Utilization" asks for a report of the patient Member Months in managed care.

Member Months: A member month is defined as 1 member being enrolled for 1 month. An individual who is a member of a plan for a full year generates 12 member months; a family of 5 enrolled for 6 months generates (5 X 6) 30 member months. Member month information can often be obtained from monthly enrollment lists generally supplied by managed care companies to their providers.

Member Months for Managed Care (capitated) (Line 13a) – Enter the total capitated member months by source of payment. This is derived by adding the total enrollment reported by the plan for each month.

Member Months for Managed care (fee-for-service) (Line 13b) – Enter the total fee-for-service member months by source of payment. A fee-for-service member month is defined as one patient being assigned to a service delivery location for one month during which time the patient may use only that center's services, but for whom the services are paid on a fee-for-service basis. NOTE: Do not include individuals who receive "carved-out" services under a fee-for-service arrangement if those individuals have already been counted for the same month as a capitated member month.

Total Member Months (Line 13c) – Enter the total of lines 13a + 13b

Characteristics of Target Populations, Lines 14 - 26

This section on "selected patient characteristics" ask for a count of persons that represent a "special population" as authorized under section 330 of the Public Health Service Act (i.e., section 330(g) Migratory and Seasonal Agricultural Workers, section 330(h) Homeless Populations, and section 330(i) Residents of Public Housing), in addition to patients served by school-based health centers, or who are veterans. (Refer to Appendix B, Glossary for a definition of all target populations.)

Migrant or Seasonal Agricultural Workers and their Dependents (Lines 14 – 16) - All organizations are required to report on Line 16 the combined total number of patients seen during the reporting period who were either migrant or seasonal agricultural workers or their dependents. FQHC Look-Alikes designated to serve section 330(g) Migratory and Seasonal Agricultural Workers are asked to provide separate totals for migrant and for seasonal agricultural workers on Lines 13 and 14. For section 330(g), Lines 14 + 15 = 16.
Homeless Patients (Lines 17 – 23) - All organizations are to report the total number of patients, known to have been homeless at the time of any service provided during the reporting period, on Line 23. Only organizations serving section 330(h) Homeless Populations will provide separate totals for homeless program patients by type of shelter arrangement.

- The shelter arrangement reported is their arrangement as of the first visit during the reporting period.
- "Street" includes living outdoors, in a car, in an encampment, in makeshift housing/shelter or in other places generally not deemed safe or fit for human occupancy.
- Persons who spent the prior night incarcerated or in a hospital should be reported based on where they intend to spend the night after their encounter. If they do not know, code as "street."
- Organizations serving section 330(h) Homeless Populations should report previously homeless patients now housed <u>but still eligible for the program</u> on Line 21, "other."

School Based Health Center Patients, Line 24 - All organizations that identified a school based health center as a service delivery site on Form 5B, Service Sites, are to report the total number of patients who received primary health care services at the school service delivery sites(s) listed.

Veterans, Line 25 - All organizations report the total number of patients served who have been discharged from the military. It is expected that this element will be added to the patient information/intake form at each center. Report only those who affirmatively indicate they are veterans. Persons who do not respond or who have no information are not counted, regardless of other indicators.

- **TABLE 5 – STAFFING AND UTILIZATION**
  This table provides a profile of the organization's staff, the number of encounters they render and the number of patients served. Unlike Tables 3 and 4, where an unduplicated count of patients is reported, Column c of Table 5 is designed to report the number of unduplicated patients <u>within each of six major service categories:</u> medical, dental, mental health, substance abuse, other professional services, and enabling. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial/cost reporting,

while ensuring adequate detail on staff categories for program planning and evaluation purposes. All staff, all encounters and all patients are reported in Columns a, b, and c.

Instructions for Completing Table 5 Column a (FTE)

This table includes FTE staffing information on all individuals who work in programs and activities that are within the scope of the project. All staff must be reported in terms of annual FTE. A person who works 20 hours per week (i.e., 50% time) is reported as "0.5 FTE." (This example is based on a 40 hour work week. Positions with less than a 40 hour base, especially clinicians, should be calculated on whatever they have as a base for that position. Agencies which have a 35 hour work week would consider 17.5 hours worked to be 0.5 FTE, etc.) Similarly, an employee who works 4 months out of the year would be reported as "0.33 FTE" (4 months/12 months). (Refer to Appendix D, Glossary for instructions on calculating FTEs).

Staff may provide services on behalf of the organization on a regularly scheduled basis under many different arrangements including, but not limited to: salaried full-time, salaried part-time, hourly wages, NHSC assignment, under contract, or donated time. Thus, FTEs reported on Table 5 Column A include paid staff, volunteers, contracted personnel (paid based on worked hours), residents and preceptors. Individuals who are paid by the organization on a fee-for-service basis only are not counted in the FTE column since there is no basis for determining their hours.

All staff time is to be allocated <u>by function</u> among the major service categories listed. For example, a full-time nurse who works solely in the provision of direct medical services would be counted as 1.0 FTE on Line 11 (Nurses). If that nurse provided case management services for 10 hours per week, and provided medical care services for the other 30 hours per week, time would be allocated 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Do not, however, attempt to parse out the components of an interaction. The nurse who vitals a patient who they then place in the exam room, and later provide instructions on wound care, for example, would not have a portion of the time counted as "health education" – it is all a part of nursing.

An individual who is hired as a full-time clinician must be counted as 1.0 FTE regardless of the number of "direct patient care" or "face-to-face hours" they provide. Providers who have released time to compensate for on-call hours or who receive leave for continuing education or other reasons are still considered full-time if this is how they were hired. The time spent by providers doing "administrative" work such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in QI activities, supervising nurses etc. is counted as part of their overall medical care services time. The one exception to this rule is when a Medical Director is engaged in <u>corporate</u> administrative activities, in which case time can be allocated to administration. Corporate administration does not, however, include clinical administrative activities such as supervising the clinical staff, chairing or attending clinical meetings, writing clinical protocols, etc. Note that Uniform Government Services (UGS), the FQHC Medicare intermediary, has different definitions for full time providers. These UGS definitions are not to be used in reporting.

For contracted providers, if the contracted provider is paid on the basis of time worked, the FTE is reported on Table 5 Column a as well as the encounters and patients receiving services from this provider. If the contracted provider is paid on a fee-for-service basis, no FTE is reported on Table 5 Column a, but encounters and patients are reported.

Residents are licensed practitioners and their time is counted just like any other practitioner. Note, however, that most work shorter days because they are in educational sessions and often have more vacation time or other time than a normal practitioner. This would make them less than full time.

Personnel by Major Service Category – Staff are distributed into categories that reflect the types of services they provide. Major service categories include: medical care services, dental services, mental health services, substance abuse services, other professional health services, pharmacy services, enabling services, other program related services, and administration and facility. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a detailed list is available on HRSA's web site at http://bphc.hrsa.gov/uds/2008manual/appendixA.htm.

- Medical Care Services (Lines 1 – 15)
  - Physicians - M.D.s and D.O.s, except psychiatrists, pathologists and radiologists. Naturopaths and Chiropractors are not counted here.
  - Nurse Practitioners
  - Physician Assistants
  - Certified Nurse Midwives
  - Nurses - registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses
  - Laboratory Personnel - pathologists, medical technologists, laboratory technicians and assistants, phlebotomists
  - X-ray Personnel - radiologists, X-ray technologists, and X-ray technicians
  - Other Medical Personnel - medical assistants, nurses aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. Medical records and patient support staff are not reported here.

- Dental Services (Lines 16 – 19)
  - Dentists - general practitioners, oral surgeons, periodontists, and pediodontists
  - Dental Hygienists
  - Other Dental Personnel - dental assistants, aides, and technicians

- Mental Health Services (Lines 20a, a1, a2, b, c and 20)
  - Psychiatrists (Line 20a)
  - Licensed Clinical Psychologists (Line 20a-1)
  - Licensed Clinical Social Workers (Line 20a-2)

- Other licensed mental health providers, including psychiatric nurses, psychiatric social workers, family therapists, and other licensed Masters Degree prepared clinicians.
- Other mental health staff, including unlicensed individuals providing counseling, treatment or support services related to mental health professionals.

- Substance Abuse Services (Line 21) - Psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists and other individuals providing counseling and/or treatment services related to substance abuse.

- All Other Professional Health Services (Line 22) - Occupational and physical therapists, nutritionists, podiatrists, optometrists, naturopaths, chiropractors, acupuncturists and other staff professionals providing health services. Note: WIC nutritionists and other professionals working in WIC programs are reported on Line 29a, Other Programs and Services Staff. There is a "specify" box that must be completed. Explain the specific other professional health services included.

- Pharmacy Services (Line 23) Pharmacists (including clinical pharmacists), pharmacist assistants and others supporting pharmaceutical services. Note that effective 2006, the time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies are to be classified as "other enabling workers," on line 28.

- Enabling Services (Lines 24 - 29)
  - Case Managers - staff who provide services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff.
  - Patient and Community Education Specialists - health educators, family planning, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.
  - Outreach Workers - individuals conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
  - Eligibility Assistance Workers - all staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF, and related assistance programs.
  - Personnel Performing Other Enabling Service Activities - all other staff performing services as enabling services, not described above.
  - Interpretation Staff - Staff whose full time or dedicated time is devoted to translation and/or interpretation services. Do not include that portion of the time

of a nurse, medical assistant or other support staff who provides interpretation or translation during the course of their other activities.

- Other Programs and Related Services Staff (Line 29a) - Some organizations, operate programs which, while within their scope of service, are not directly a part of their medical or social health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, etc. The staff for these programs are reported under Other Programs and Related Services.

- Administration and Facility (Lines 30 - 33)
  - Management and Support Staff – (Line 30a) - Staff providing management and administrative office support for health center operations within the scope of project, not including the Chief Financial Officer or the Chief Medical Officer.
  - Fiscal and Billing Staff – (Line 30b) - Staff performing fiscal and accounting functions in support of health center operations within scope of the project, including the Chief Financial Officer, and staff performing billing functions for services performed within the scope of the project.
  - IT Staff – (Line 30c) - Technical information technology and information systems staff supporting the maintenance and operation of the computing systems that support clinical and administrative functions performed within the scope of the project.
  - Facility – (Line 31) - staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff.
  - Patient Services Support Staff – (Line 32) - intake staff and medical/patient records.

  Note: The Administration and Facility category for this report is more comprehensive than that used in some other program definitions and includes all personnel working to support the scope of project.

Instructions for Completing Table 5 Column b (encounters) and Column c (patients)
Encounters (Column b) – An encounter is a documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. (Further details on the definition of encounters are available on HRSA's web site at http://bphc.hrsa.gov/uds/2008manual/appendixA.htm.) Organizations are to report encounters during the reporting period rendered by staff identified in Column a, regardless of whether the staff are salaried or contracted based on time worked. No encounters are reported for personnel who are not "providers who exercise independent professional judgment" within the meaning of the definition above. In addition, organizations are not required to report on encounters for certain other classes of staff, even if they do exercise professional judgment.

Encounters that are purchased from non-staff providers on a fee-for-service basis are also counted in this column, even though no corresponding FTEs are included in Column a. To be counted, the service must meet the following criteria:

1. the service was provided to a patient of the organization by a provider that is not part of the organization's staff (neither salaried nor contracted on the basis of time worked),
2. the service was paid for in full by the organization, and
3. the service otherwise meets the above definition of an encounter.

This category does not include unpaid referrals, or referrals where only nominal amounts are paid, or referrals for services that would otherwise not be counted as encounters.

If you have group treatment sessions (e.g., for substance abuse or mental health) you must record the encounter in each participant's chart and then record an encounter for each participant. If an encounter is not recorded in a participant's chart, that participant may not be counted as a patient. No group medical encounters are counted on Table 5. Though in some instances they may be billable as counseling services, HRSA specifically does not count as encounters activities in such sessions.

Patients (Column c) – A patient is an individual who has at least one encounter during the reporting year. Report the number of patients for each of the six separate services listed below. Within each category, an individual can only be counted once as a patient. A person who receives multiple types of services should be counted once (and only once) for each service.

For example, a person receiving only medical services is reported once (as a medical patient) regardless of the number of encounters made. A person receiving medical, dental and enabling services is reported once as a medical patient (Line 15), once as a dental patient (Line 19) and once as an enabling patient (Line 29), but is counted only once on each appropriate line in Column c, regardless of the number of visits reported in Column b. An individual patient may be counted once (and only once) in each of the following categories:

- Medical care services patients (Line 15)
- Dental services patients (Line 19)
- Mental health services patients (Line 20)
- Substance abuse services patients (Line 21)
- Patients of other professional services (Line 22)
- Enabling services patients (Line 29)

If you show encounters in Column b for any of these six categories, you are required to show the unduplicated number of persons who received these encounters. Since patients must have at least one documented encounter, it is not possible for the number of patients to exceed the number of encounters. Also, individuals who only receive services for which no encounters are generated (e.g., laboratory, transportation, outreach) are not included in the patient count reported in Column c. For example, individuals who receive outreach or transportation services are not included in the total number of patients receiving enabling services in Column c; individuals who received flu shots but no other service are not counted as medical users, etc.

If a clinician provides mental health and substance abuse (behavioral health) services to the same patient during an encounter, it is permissible to count the encounter as mental health.

Under no circumstances would it be counted as “one of each.” The provider will also need to be classified as mental health for this encounter.

OMB No.: 0915-0285. Expiration Date: 08/31/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 1A: GENERAL INFORMATION WORKSHEET	FOR HRSA USE ONLY	
	Project Period Start:	**Project Period End:**

1. Applicant Information	
Applicant Name	
Application Type	**[_]** Initial Designation **[_]** Renewal of Designation **[_]** Annual Recertification **[_]** Change in Scope of Project
Section 330 Population Served	**[_]** Section 330(e) – General Community **[_]** Section 330(g) – Migratory/Seasonal Agricultural Workers **[_]** Section 330(h) – Homeless Populations **[_]** Section 330(i) – Residents of Public Housing
Business Entity	
Organization Type	**[_]** Tribal **[_]** Urban Indian **[_]** Faith based **[_]** Hospital **[_]** State government **[_]** City/County/Local Government or Municipality **[_]** University **[_]** Community based organization

2. Service Area
Applicants applying for section 330(e) designation should provide at least one designated service area ID being served under an MUA or MUP.

2a. Service Area Designation	**[_]** Medically Underserved Area (ID#____) **[_]** Medically Underserved Population (ID#____) **[_]** MUA Application Pending (ID#____) **[_]** MUP Application Pending (ID#____)
2b. Target Population Type	**[_]** Urban **[_]** Rural **[_]** Sparsely Populated

GENERAL INFORMATION Refer to the guidance to accurately complete the below information.
2c. Target Population and Provider Information

Target Population Information	**CURRENT NUMBER**	**Projected at FULL CAPACITY**
Total SERVICE AREA POPULATION		
Total TARGET POPULATION		
Total FTE Medical Providers		
Total FTE Dental Providers		
Total FTE Behavioral Health Providers		
Total FTE Substance Abuse Service Providers		

Data reported below should not be duplicated for users and visits.
Patients and Visits by Service Type

SERVICE TYPE	**CURRENT NUMBER**		**Projected at FULL CAPACITY**	
	PATIENTS	**VISITS**	**PATIENTS**	**VISITS**
Total Medical				

Total Dental												
Total Mental Health												
Total Substance Abuse												

Patients and Visits by Population Type

POPULATION TYPE	(b) CURRENT NUMBER		NUMBER AT END OF Yr1		(c) NUMBER AFTER 2 YEAR		NUMBER AT FULL CAPACITY		(d) CHANGE IN NEW USERS AFTER 2 YEARS (c-b)		(e) PERCENT CHANGE IN NEW USERS AFTER 2 YEARS (d/b)*100	
	Patient	Visit	Patient	Visit	Patient	Visit	Patient	Visits	Patient	Visit	Patient	Visit
General Community												
Migrant/Seasonal Farm workers												
Homeless Populations												
Public Housing Residents												
TOTAL												

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[1] This should include Incident Reporting System and Risk Management Plans/Policies

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 3 - INCOME ANALYSIS FORM	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY		
	Applicant Name		
	Project Period Start:		Project Period End:

PART 1: NON FEDRAL SHARE, PROGRAM INCOME								
Payor Category	Number Of Visits	Average Charge Per Visit	Gross Charges (a * b)=(c)	Average Adjustment Per Visit	Net Charges (Amount Billed) [c-(a*d)]	Collection Rate (%)	Projected Income (e * f)	Actual Accrued Income Past 12 Months
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
PROJECTED/CTUAL FEE FOR SERVICE INCOME								
1a. Medicaid: Medical								
1b. Medicaid: EPSDT (if different from medical rate)								
1c. Medicaid: Dental								
1d. Medicaid: MH/SA								
1e. Medicaid: other fee for Service								
1. Subtotal: Medicaid								
2a. Medicare: all inclusive FQHC rate								
2b. Medicare: other Fee for Service								
2. Subtotal: Medicare								
3a. Private Insurance (Medical)								
3b. Private Insurance (Dental)								
3c. Private Insurance (MH/SA)								
3. Subtotal: Private								
4a. Self-Pay: 100% charge, no discount (Medical)								
4b. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Medical)								
4c. Self-Pay: 100% charge, no discount (Dental)								
4d. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Dental)								
4e. Self-Pay: 100% charge, no discount (MH/SA)								
4f. Self-Pay: 0% - 99% of								

charge, sliding discount including full discount, (MH/SA)								
4. Subtotal: Self Pay								
5. Subtotal: Other Public								
6. TOTAL FEE FOR SERVICE								

PROJECTED MANAGED CARE INCOME						
TYPE OF PAYOR	**Number of Member Months (a)**	**Rate Per Member Month (b)**	**Risk Pool Adjustment (c)**	**FQHC and Other Adjustments (d)**	**Projected Gross Income (e)**	**Actual Gross Income Previous 12 months (f)**
7a. Medicaid:						
7b. Medicare						
7c. Commercial						
7d. Other Public						
7. TOTAL CAPITATED MANAGED CARE						
8. Managed Care Charges	**(a) Visits**		**(b) Average Charge Per Visit**		**(c) Total Charges**	**Total Actual**
TOTAL PROGRAM INCOME [line 6, column g + line 7, column e]						

PART 2: NON FEDRAL SHARE, OTHER INCOME	
	Total Other Income by Source
9. Applicant	
10. State Funds	
11. Local Funds	
Other Support	
12a. Other Federal Grants	
12b. Contributions and Fundraising	
12c. Foundation Grants	
12d. Other_____(please list)	
12. Subtotal Other Support	
13. TOTAL OTHER INCOME	
TOTAL NON-FEDERAL SHARE [line6, row (g) + line 7, row (e) + line 13]	
Comments/Explanatory Notes for Income Analysis Form (if applicable):	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 4 - COMMUNITY CHARACTERISTICS	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY			
	Applicant Name			
	Project Period Start:		Project Period End:	

	CHARACTERISTIC	SERVICE AREA DATA		TARGET POPULATION DATA	
		#	%	#	%
RACE	Native Hawaiian				
	Other Pacific Islander				
	Asian				
	Black/African American				
	American Indian/Alaskan Native				
	White				
	More than one race				
	Unreported/Refused to report (if applicable)				
	Total:		100%		100%
HISPANIC OR LATINO IDENTITY	Hispanic or Latino				
	All others including unreported				
	Total:		100%		100%
INCOME AS A PERCENT OF POVERTY LEVEL	Below 100%				
	100-199 percent				
	200 percent and above				
	Unknown				
	Total:		100%		100%
PRIMARY THIRD PARTY PAYMENT SOURCE	Medicaid/Capitated				
	Medicaid/Not Capitated				
	Medicare				
	Other Public Insurance				
	Private Insurance, including capitation				
	None/Uninsured				
	Total:		100%		100%
SPECIAL POPULATIONS	Migratory/Seasonal Agricultural workers and Families				
	Homeless				
	Residents of Public Housing				
	HIVAIDS-Infected Persons				
	Persons with Mental Health/Substance Abuse Needs				
	School Age Children				
	Infants Birth to 2 years of Age				
	Women Age 25-44				
	Persons Age 65 and Older				
	Other: (Please Specify)				

Please note that all information provided regarding race and/or ethnicity will be used only to ensure compliance with statutory and regulatory governing board requirements. Data on race and/or ethnicity collected on this form will not be used as a factor for recommending FQHC Look-Alike designation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5A: SERVICES PROVIDED	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY	
	Project Period Start:	**Project Period End:**

SERVICE TYPE	MODE OF SERVICE PROVISION		
	APPLICANT	AGREEMENT (Grantee pays for service)	REFERRAL ARRANGEMENTS (Grantee DOES NOT pay)
Required Services			
Clinical Services			
General Primary Medical Care			
Diagnostic Laboratory			
Diagnostic X-Ray			
Screenings			
• Cancer			
• Communicable Diseases			
• Cholesterol			
• Blood lead test for elevated blood lead level			
• Pediatric vision, hearing and dental			
Emergency Medical Services			
Voluntary Family Planning			
Immunizations			
Well Child Services			
Gynecological Care			
Obstetrical Care			
Prenatal and Perinatal Services			
Preventive Dental			
Referral to Mental Health[1]			
Referral to Substance Abuse[1]			
Referral to Specialty Services			
Pharmacy			
Substance Abuse services (required for HCH programs):			
• Detoxification			
• Outpatient Treatment			
• Residential Treatment			
• Rehabilitation (non hospital settings)			
Non - Clinical Services			
Case Management			
• Counseling/Assessment			
• Referral			
• Follow-up/Discharge Planning			
• Eligibility Assistance			
Health Education			
Outreach			

Transportation			
Translation[2]			
Substance abuse services (required for HCH programs):			
• Harm/Risk Reduction (e.g. educational materials, nicotine gum/patches)			
Additional Services (Optional)			
Clinical Services			
Urgent Medical Care			
Dental Services			
• Restorative			
• Emergency			
Mental Health Services			
• Treatment/Counseling			
• Developmental Screening			
• 24-Hour Crisis			
Substance Abuse Services			
Recuperative Care			
Environmental Health Services			
Occupational-Related Health Services[3]			
• Screening for Infectious Diseases			
• Injury Prevention Programs			
Occupational Therapy			
Physical Therapy			
HIV Testing			
TB Therapy			
Podiatry			
Rehabilitation (Non-Hospital Settings)			
Other:			
Non Clinical Services			
WIC			
Nutrition (not WIC)			
Child Care			
Housing Assistance			
Employment and Education Counseling			
Food Bank/Meals			
Other:			

1. Applicants are required to provide mental health and substance abuse services by referral arrangements. However, applicants may provide these services by applicant or formal agreement in addition to by referral arrangements under additional services.
2. Required for Health Centers serving a substantial number of patients with limited English-Proficiency.
3. Additional Services for Health Centers serving Migratory and Seasonal Agricultural Workers (MSAWs).

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5B: SERVICE SITES	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY	
	Project Period Start:	Project Period End:

Site Information			
Name of Service Site			
Service Site Type	[_] Administrative [_] Service Delivery [_] Administrative/Service Delivery		
Location Type	[_] Permanent [_] Seasonal [_] Mobile Van [_] Voucher Screening [_] Intermittent		
Location Setting	[_] Hospital [_] School [_] Tribal [_] Nursing Home [_] Domestic Violence Shelter [_] Correctional Facility [_] All Other Clinic Types		
Number of Contract Service Delivery Locations (Voucher Screening Only)		Number of Intermittent Sites (Intermittent Only)	
Web URL			
Site Operated by	[_] Applicant [_] Contractor [_] Co-Applicant (Public Centers Only)		

If Site is operated by a Contractor or Co-Applicant please provide the organization information below:

Organization	
Organization Name	
Address (Physical)	
Address (mailing)	
EIN	

Date Site was Opened		Date Site was Added to Scope	
Physical Site Address			
Site Mailing Address			
Medicare Billing Number		Medicaid Billing Number	
Medicaid Pharmacy Billing Number		Site Phone Number	
Site Fax Number		Administration Phone Number	
Service Area Zip codes			
Service Area Census Tracts			
Service Area Population (Check all that apply)	[_] Urban [_] Rural [_] Sparsely Populated [_] Serving Section 330 (e) – General Community [_] Serving Section 330 (g) – Migratory/Seasonal Agricultural Workers [_] Serving Section 330 (h) – Homeless Populations [_] Serving Section 330 (i) – Residents of Public Housing		
Operational Schedule	[_] Full-Time [_] Part-Time	Calendar Schedule	[_] Year-Round [_] Seasonal
Total Hours of Operation when Patients will be Served per Week (include extended hours)			
Months of Operation (Required for permanent and seasonal locations)			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5C: OTHER ACTIVITIES/LOCATIONS	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY	
	Project Period Start:	Project Period End:

ACTIVITY/LOCATION	
Type of Activity	
Description of Activity	
Frequency of Activity	
Type of Location(s) where Activity is Conducted	
ACTIVITY/LOCATION	
Type of Activity	
Description of Activity	
Frequency of Activity	
Type of Location(s) where Activity is Conducted	
ACTIVITY/LOCATION	
Type of Activity	
Description of Activity	
Frequency of Activity	
Type of Location(s) where Activity is Conducted	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 6A: CURRENT BOARD MEMBER CHARACTERISTICS	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY			
	Applicant Name			
	Project Period Start:		Project Period End:	

BOARD MEMBER NAME	BOARD OFFICE HELD	AREA OF EXPERTISE (Place asterisk (*) if member derives more than 10% of income from health industry)	INDICATE IF HEALTH CENTER PATIENT (YES/NO)	LIVE (L) OR WORK (W) IN SERVICE AREA	YEARS OF CONTINUOUS BOARD SERVICE

Indicate # Board Members by Gender: F = M =

Indicate # Board Members by Ethnicity & Race:

Hispanic Origin: Hispanic or Latino:

Race: White: Black/African American: Asian:

Native Hawaiian or Other Pacific Islander: American Indian or Alaska Native: More Than One Race:

NOTES: (1) Please indicate if a board member is a special population representative (MHC, HCH, PHPC).

(2) MHC, HCH, and/or PHPC applicants requesting a waiver of the governance requirements must complete Form 6 - Part B and describe any alternative arrangement for addressing Board requirements including the mechanism for receiving consumer input.
(3) Tribal entities are exempt from Governance Requirements.
(4) Add additional pages, if needed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration** **FORM 6B: REQUEST FOR WAIVER OF GOVERNANCE REQUIREMENTS**	OMB No.: 0915-0285. Expiration Date: 08/31/2010 **FOR HRSA USE ONLY**	
	Project Period Start:	Project Period End:

1. Request for Waiver	
Name of Organization	
1a. Are you requesting a waiver of governance requirements?	**[_]** Yes **[_]** No **[_]** Not Applicable
2. For applicants with previous waiver	
2a. Nature of Items Currently Approved to be Waived	**[_]** 51 Percent Patient Majority **[_]** Monthly Meetings
2b. Are you requesting the waiver be continued?	**[_]** Yes (Complete next question) **[_]** No (Governing Board is in Full Compliance)
2c. Is your waiver request based on arrangements that are different from your original request?	**[_]** Yes **[_]** No
3. New Waiver Request	
3a. Nature of Items for New Waiver Request	**[_]** 51 Percent Patient Majority **[_]** Monthly Meetings
4. All Organizations Requesting Waiver: Describe the appropriate alternative strategies in place that will assure consumer/patient participation and/or regular oversight in the direction and ongoing governance of the organization.	
4a. Strategy 1	
4b. Strategy 2	
4c. Other Strategies	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 8: HEALTH CENTER AFFILIATION CERTIFICATION/CHECKLIST	OMB No.: 0915-0285. Expiration Date: 8/31/2010 **FOR HRSA USE ONLY**	
	Project Period Start:	Project Period End:

Does your organization have, or propose to establish as part of this application, any of the following Affiliation Types:

- Contract for a substantial portion of the approved scope of project
- Memorandum of Understanding (MOU)/Agreement (MOA) for substantial portion of the approved scope
- Contract with another organization or individual contract for core primary care providers
- Contract with another organization for staffing health center
- Contract with another organization for the Chief Medical Officer (CMO) or Chief Financial Officer (CFO)
- Merger with another organization
- Parent Subsidiary Model arrangement
- Acquisition by another organization
- Establishment of a New Entity (e.g. Network corporation)
- Co-Applicant Agreement

[ ] Yes (Please complete sections **Organization Affiliations** Section)
[ ] No
[ ] Not Applicable (Choose this option if you are **NOT** a CHC/MHC applicant)

NOTE: You must complete a checklist for each organization with which you have any of the above arrangements. Copies of all applicable documents must be included with the application.

Organization Affiliation Details	
Organization Name	
EIN	
Address	

Check all that apply

[_] Contract for a substantial portion of the approved scope of project
[_] Memorandum of Understanding (MOU)/Agreement (MOA) for substantial portion of the approved scope
[_] Contract with another organization or individual contract for core primary care providers
[_] Contract with another organization for staffing health center
[_] Contract with another organization for the Chief Medical Officer (CMO) or Chief Financial Officer (CFO)
[_] Merger with another organization
[_] Parent Subsidiary Model arrangement
[_] Acquisition by another organization
[_] Establishment of a New Entity (e.g. Network corporation)

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration HEALTH CENTER AFFILIATION CHECKLIST	OMB No.: 0915-0285. Expiration Date: 08/31/2010 **FOR HRSA USE ONLY**			
	Applicant Name			
	Project Period Start:		Project Period End:	

STAFFING:	**YES**	**NO**
1) The center directly employs the CFO, CMO and the core staff of full-time primary care providers.	[_]	[_]
2) The center directly employs all non-provider health center staff.	[_]	[_]
If NO to question 1 or 2, the CEO of the center retains the authority to select and dismiss the CFO and CMO as well as other staff assigned to the center? Please cite reference document and page # (_____)	[_]	[_]
GOVERNANCE:	**YES**	**NO**
3) The arrangements presented in the affiliation agreements, as defined in FORM 8, do not compromise the Board authorities or limit its legislative and regulatory mandated functions and responsibilities as defined below. *(Examples of compromising arrangements are: overriding approval or veto authority by another entity; dual majority requirements; super-majority requirements; or hiring and dismissal of the CEO).*	[_]	[_]
	Reference Document	**Page #**
• board composition		
• executive committee function and composition		
• selection of board chairperson		
• selection of board members		
• strategic planning		
• approval of the annual budget of the center		
• directly employs, selects/dismisses and evaluates the Chief Executive Officer/Executive Director		
• adoption of policies and procedures for personnel and financial management		
• establishes center priorities		
• establishes eligibility requirements for partial payment of services		
• provides for an independent audit		
• evaluation of center activities		
• adoption of center's health care policies including scope and availability of services, location, hours of operation and quality of care audit procedures		
• existence of a conflict of interest policy		
• contains appropriate provisions around the activities to be performed, time, schedules, the policies and procedures to be followed in carrying out the agreement, and the maximum amount of money for which the grantee may become liable to the contractor under the agreement;		
• requires the contractor to maintain appropriate financial, program and property management systems and records in accordance with 45 C.F.R. Part 74 or Part 92, as applicable, and provides the center, DHHS and the U.S. Comptroller General with access to such records;		
• requires the submission of financial and programmatic reports to the health center;		
• complies with Federal procurement standards and grant requirements including conflict of interest standards;		
• subject to termination (with administrative, contractual and legal remedies) in the event of breach by the contractor.		
CONTRACTING:	**YES**	**NO**
4) The center has justified the performance of the work by a third party. Please cite reference document and page # (_____)	[_]	[_]
5) Written affiliation agreement(s) comply with current Department of Health and Human Services (HHS) policies (PINs 97-27 and 98-24)	[_]	[_]

INCLUDE LIST AND COPIES OF ALL RELEVANT AND CITED DOCUMENTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 10: ANNUAL EMERGENCY PREPAREDNESS REPORT	OMB No.: 0915-0285. Expiration Date: 8/31/2010 FOR HRSA USE ONLY	
	Project Period Start:	**Project Period End:**

SECTION I - EMERGENCY PREPAREDNESS AND MANAGEMENT PLAN	
1. Has your organization conducted a thorough Hazards Vulnerability Assessment? If Yes, the date completed:	[_] Yes [_] No
2. Does your organization have EPM plans? *If Yes, the date most recent EPM plan was approved by your Board*: *If No, skip to Readiness section below.*	[_] Yes [_] No
3. Does the EPM plan specifically address the four disaster phases?	
3a. Mitigation?	[_] Yes [_] No
3b. Preparedness?	[_] Yes [_] No
3c. Response?	[_] Yes [_] No
3d. Recovery?	[_] Yes [_] No
4. Is your EPM plan integrated into your local/regional emergency plan?	[_] Yes [_] No
5. If No, has your organization attempted to participate with local/regional emergency planners?	[_] Yes [_] No
6. Does the EPM plan address your capacity to render mass immunization/prophylaxis?	[_] Yes [_] No
SECTION II - READINESS	
1. Does your organization include alternatives for providing primary care to your current patient population if you are unable to do so during emergency?	[_] Yes [_] No
2. Does your organization conduct annual planned drills?	[_] Yes [_] No
3. Does your organization's staff receive periodic training on disaster preparedness?	[_] Yes [_] No
4. Will the organization be required to deploy staff to Non-Health Center sites/locations according to emergency preparedness plan for the local community?	[_] Yes [_] No
5. Does your organization have arrangements with Federal, State and/or local agencies for reporting of data?	[_] Yes [_] No
6. Does your organization have a back up communication system?	[_] Yes [_] No
6a. Internal?	[_] Yes [_] No
6b. External?	[_] Yes [_] No
7. Does your organization coordinate with other systems of care to provide an integrated emergency response?	[_] Yes [_] No
8. Has your organization been designated to serve as a point of distribution (POD) for providing antibiotics, vaccines and medical supplies?	[_] Yes [_] No
9. Has your organization implemented measures to prevent financial/revenue and facilities loss due to an emergency? (e.g. Insurance coverage for short-term closure)	[_] Yes [_] No
10. Does your organization have an off-site back up of your information technology system?	[_] Yes [_] No
11. Does your organization have a designated EPM coordinator?	[_] Yes [_] No

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 12: ORGANIZATION CONTACTS	OMB No.: 0915-0285. Expiration Date: 08/31/2010 FOR HRSA USE ONLY	
	Project Period Start:	Project Period End:

Medical Director	
Name	
Phone	
Email	
Dental Director	
Name	
Phone	
Email	
Contact Person	
Title of Position	
Name	
Phone	
Email	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration Electronic Health Records (EHR)	FOR HRSA USE ONLY	
	Project Period Start:	Project Period End:

* 1. Does your health center use ELECTRONIC HEALTH RECORDS (not including billing records)?
(Skip to question 4, if you answer 'No or Don't Know')

[_] Yes, all electronic
[_] Yes, part paper and part electronic
[_] No or Don't Know

2. Is the EHR system certified by the U.S. Department of Health and Human Services?

[_] Yes **[_]** No **[_]** N/A

3. Which of your clinical programs use an electronic system? Of the clinical programs with an electronic system, indicate each program that is integrated within your health center's EHR.

Clinical Program	Electronic System Check if system present	Integrated into EHR Check if integrated into EHR
Medical	**[_]**	**[_]**
Oral/Dental	**[_]**	**[_]**
Mental Health and Substance Abuse	**[_]**	**[_]**
Pharmacy	**[_]**	**[_]**
ePrescribing	**[_]**	**[_]**
Lab	**[_]**	**[_]**
X-Ray	**[_]**	**[_]**
Other *If 'Other', please specify:*	**[_]**	**[_]**
Other *If 'Other', please specify:*	**[_]**	**[_]**
Other *If 'Other', please specify:*	**[_]**	**[_]**
Other *If 'Other', please specify:*	**[_]**	**[_]**

*4. Are there plans for installing a new EHR system or replacing the current system?
(Answer to this question is mandatory, if you answer 'No or Don't Know' to Question 1)

[_] Install a new EHR within 12 months
[_] Install a new EHR within 13-36 months
[_] Not install an EHR
[_] Unknown

Table 3A – Patients by Age and Gender

Age Groups		Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25 – 29		
27	Ages 30 – 34		
28	Ages 35 – 39		
29	Ages 40 – 44		
30	Ages 45 – 49		
31	Ages 50 – 54		
32	Ages 55 – 59		
33	Ages 60 – 64		
34	Ages 65 – 69		
35	Ages 70 – 74		
36	Ages 75 – 79		
37	Ages 80 – 84		
38	Ages 85 and over		
39	**Total Patients (Sum Lines 1 – 38)**		

Table 3B – Patients by Ethnicity/Race/Language

Patients by Ethnicity		Number (a)
1.	Hispanic or Latino	
2.	All others including unreported	
3.	<<not used>>	
4.	**Total Patients (Sum Lines 1 – 3)**	

Patients by Race		Number (a)
5b.	Native Hawaiian	
5c.	Other Pacific Islander	
5.	**Total Hawaiian/Pacific Islander (Sum Lines 5b + 5c)**	
5a.	Asian	
6.	Black/African American	
7.	American Indian/Alaska Native	
8.	White	
9.	More than one race	
10.	Unreported/Refused to report	
11.	**Total Patients (Sum Lines 5 + 5a + 6 - 10)**	

Patients by Language		Number (a)
12.	Patients Best Served in a Language Other Than English	

Table 4 – Selected Patient Characteristics

Income as Percent of Poverty		Number of Patients (a)
1.	100% and below	
2.	101% - 150%	
3.	151% - 200%	
4.	Over 200%	
5.	Unknown	
6.	**Total (Sum lines 1 – 5)**	

Principal Third Party Medical Insurance Source		0 – 19 Years Old (a)	20 and Older (b)
7.	None/Uninsured		
8a.	Regular Medicaid (Title XIX)		
8b.	CHIP Medicaid		
8.	**Total Medicaid (Line 8a +8b)**		
9.	**Medicare (Title XVIII)**		
10a.	Other Public Insurance Non-CHIP (Specify)		
10b.	Other Public Insurance CHIP		
10.	**Total Public Insurance (Line 10a + 10b)**		
11.	**Private Insurance**		
12.	**Total (Sum Lines 7 + 8 + 9 + 10 + 11 + 12)**		

Managed Care Utilization Payor Category		Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid S-CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months					
13b.	Fee-for-service Member Months					
13c.	**Total Member Months (13a + 13b)**					

Special Populations		Number of Patients (a)
14.	Migrant – section 330(g) only	
15.	Seasonal – section 330(g) only	
16.	**Total Migrant/Seasonal Agricultural Worker or Dependent (all organizations report this line)**	
17.	Homeless Shelter – section 330(h) only	
18.	Transitional – section 330(h) only	
19.	Doubling Up – section 330(h) only	
20.	Street – section 330(h) only	
21.	Other – section 330(h) only	
22.	Unknown – section 330(h) only	
23.	**Total Homeless (all organizations report this line)**	
24.	**Total School Based Health Center (all organizations report this line)**	
25.	**Total Veterans (all organizations report this line)**	

Table 5 – Staffing and Utilization

Personnel by Major Service Category		FTEs (a)	Clinic Encounters (b)	Patients (c)
1.	Family Physicians			
2.	General Practitioners			
3.	Internists			
4.	Obstetrician/Gynecologists			
5.	Pediatricians			
6.	<<not used>>			
7.	Other Specialty Physicians			
8.	**Total Physicians (lines 1 – 7)**			
9a.	Nurse Practitioners			
9b.	Physician Assistants			
10.	Certified Nurse Midwives			
10a.	**Total Mid-Levels (Lines 9a – 10)**			
11.	Nurses			
12.	Other Medical Personnel			
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Lines 8 + 10a – 14)**			
16.	Dentists			
17.	Dental Hygienists			
18.	Dental Assistants, Aides, Techs			
19.	**Total Dental Services (Lines 16 – 18)**			
20a.	Psychiatrists			
20a1.	Licensed Clinical Psychologists			
20a2.	Licensed Clinical Social Workers			
20b.	Other Licensed Mental Health Providers			
20c.	Other Mental Health Staff			
20.	**Total Mental Health (Lines 20a – 20c)**			
21.	**Substance Abuse Services**			
22.	**Other Professional Services**			
23.	**Pharmacy Personnel**			
24.	Case Managers			
25.	Patient/Community Education Specialists			
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers			
27b.	Interpretation Staff			
28.	Other Enabling Services			
29.	**Total Enabling Services (Lines 24 – 28)**			
29a.	**Other Programs/Services (Specify)**			
30a.	Management and Support Staff			
30b.	Fiscal and Billing Staff			
30c.	IT Staff			
30.	**Total Administrative Staff (Lines 30a – 30c)**			
31.	Facility Staff			
32.	Patient Support Staff			
33.	**Total Admin & Facility (Lines 30 – 32)**			
34.	**Total (Lines 15 + 19 + 20 + 21 + 22 + 23 + 29 + 29a + 33)**			